IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA

LONNIE CAMMON, (AIS #236498),	*	
	*	
Plaintiff,	*	
V.	*	2:06-cv-674-WKW
DOCTOR SEDIET and PRISON HEALTH SERVICES,	*	
Defendants.	*	

SPECIAL REPORT OF DEFENDANTS PRISON HEALTH SERVICES, INC. AND TAHIR SIDDIQ, M.D.

COME NOW Defendants Prison Health Services, Inc. (identified in the Plaintiff's Amended Complaint as "PMS Prison Medical Services") (hereinafter PHS) and Tahir Siddiq, M.D. (incorrectly identified in the Plaintiff's Complaint as "Doctor Sediet") in response to this Honorable Court's Order and present the following Special Report with regard to this matter:

I. INTRODUCTION

The Plaintiff, Lonnie Cammon (AIS# 236498) is a 76 year old inmate currently confined at Bullock County Correctional Facility located in Union Springs, Alabama. On July 31, 2006, Cammon filed a Complaint against Defendant PHS, the company that currently contracts with the Alabama Department of Corrections to provide healthcare to inmates at Bullock and other correctional facilities throughout the State of Alabama and Tahir Siddiq, M.D., Bullock's Medical Director, alleging that the nursing staff at Easterling Correctional Facility provided him with improper medication that caused him to have a stroke. (See Complaint). Pursuant to court order the Plaintiff amended his

Complaint on August 23, 2006 to add claims that Dr. Siddiq failed to provide the Plaintiff with inappropriate medical care on August 5, 2006 and August 11, 2006. (See Amended Complaint). The Plaintiff further claims that Dr. Siddiq has acted inappropriately in failing to send him to a specialist for evaluation. (Id.) The Plaintiff demands that the Court issue an Order requiring that PHS send him to an "outside" care provider for unspecified medical treatment. (Id.) He also demands $100,000,000,000 in damages. (Id.)

As directed, the Defendants have undertaken a review of Plaintiff Cammon's claims to determine the facts and circumstances relevant thereto. At this time, the Defendants are submitting this Special Report, which is supported by a Certified Copy of Plaintiff Cammon's medical records (attached hereto as Exhibit "A"), the Affidavit of Tahir Siddiq, M.D. (attached hereto as Exhibit "B") and the Affidavit of Kay Wilson, R.N., H.S.A. (attached hereto as Exhibit "C"). These evidentiary materials demonstrate that Plaintiff Cammon has been provided appropriate medical treatment for his complaints at all times, and that the allegations in his Complaint are without merit.

II. NARRATIVE SUMMARY OF FACTS

At all pertinent times, Lonnie Cammon (AIS# 236498) has been incarcerated as an inmate at Bullock and Easterling Correctional Facilities. (See Exhibits "A" – "C"). Cammon has been seen and evaluated by the medical or nursing staff at Easterling and Bullock, and has been referred to an appropriate care provider and given appropriate care, each time he has registered any health complaints at these facilities. (Id.)

Mr. Cammon has filed a Complaint in this matter alleging that Dr. Siddiq failed to provide him with appropriate medical care on August 5, 2006 and August 11, 2006. (See Amended Complaint). Mr. Cammon does not, however, specify how Dr. Siddiq has

failed to treat him appropriately. (Id.) He also states that that Dr. Siddiq has acted inappropriately in failing to refer him specialty evaluation. (Id.) Mr. Cammon's allegations are completely unfounded. (See Exhibits "A" & "B").

Mr. Cammon was transferred to Bullock County Correctional Facility on May 31, 2006. (See Exhibit "A"). Dr. Siddiq evaluated Mr. Cammon on June 1, 2006 for complaints of swelling in the left arm. (Id.) Dr. Siddiq provided Mr. Cammon with a physical evaluation and determined that he had swelling of the left elbow with tenderness. (Id.) He exhibited strong pulses. (Id.) Dr. Siddiq prescribed him a Decadron (corticosteroid) injection to combat swelling. (Id.) He was prescribed Naproxen for pain. (Id.)

On June 2, 2006 fluid was taken from Mr. Cammon's elbow. (Id.) It was determined that he did not suffer from gout. (Id.) On July 10, 2006, Dr. Siddiq again evaluated Mr. Cammon and determined that his swelling was greatly reduced. (Id.) He exhibited good range of motion. (Id.) On July 17, 2006, Mr. Cammon presented again with swelling in the forearm. (Id.) Dr. Siddiq started Mr. Cammon on prednisone. (Id.)

Contrary to the allegations in his Complaint, Mr. Cammon did not present to the healthcare unit for treatment on either August 5, 2006 or August 11, 2006. (Id.) In fact, he did not present for treatment at all during the month of August 2006. (Id.) He presented to the healthcare unit again on September 11, 2006 with renewed complaints for elbow and back pain. (Id.) He refused further treatment at that time. (Id.) Specialty evaluation is not medically indicated for Mr. Cammon's treatment. (Id.)

Mr. Cammon has also alleged that the nursing staff at Easterling failed to provide him with appropriate medications during the year 2006 and, as a result of this failure, he

was caused to suffer a stroke. (See Complaint). Mr. Cammon's allegations are simply unfounded. (See Exhibits "A" - "C").

Mr. Cammon was maintained with numerous medications while incarcerated at Easterling during the year 2006. (See Exhibit "C"). Specifically, Mr. Cammon was prescribed Ditropan[1], NitroQuick/Nitroglycerin[2], Aspirin[3], Mevacor[4], Tylenol, KCL, Bactrim[5], Isordil[6], Lasix[7], Zantac[8], Prednisone[9], Feldene[10] Cosopt[11], Colchicine[12], Artificial tears, Miconazole Cream[13] and Bengay. (Id.) These medications were prescribed to Mr. Cammon by Easterling's Medical Director, Jean Darbouze, M.D., and were adjusted by Dr. Darbouze as warranted by his changing medical condition. (Id.) The nursing staff at Easterling gave Mr. Cammon his medications as prescribed. (Id.) There is no indication that any of Mr. Cammon's medications have caused him to suffer a stroke. (Id.)

All of Mr. Cammon's medical conditions and complaints have been evaluated and treated in a timely and appropriate fashion. (See Exhibits "A"-"C"). Mr. Cammon has been seen and evaluated by the medical or nursing staff, and he has been referred to an

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[1] Ditropan is indicated to help control the symptoms of overactive bladder.
[2] Nitroglycerin dilates blood vessels to prevent angina.
[3] Prevention and treatment of stroke and heart attack.
[4] Mevacor is indicated for treatment of high cholesterol.
[5] Bactrim is an antibiotic.
[6] Isordil is prescribed to relieve or prevent angina pectoris. Isordil dilates the blood vessels by relaxing the muscles in their walls.
[7] Lasix is a loop diuretic (water pill) that prevents the body from absorbing too much salt, allowing the salt to instead be passed in urine.
[8] Zantac is in a class of drugs called histamine receptor antagonists. Zantac works by decreasing the amount of acid the stomach produces.
[9] Prednisone is used alone or with other medications to treat the symptoms of low corticosteroid levels (lack of certain substances that are usually produced by the body and are needed for normal body functioning).
[10] Feldene, a nonsteroidal anti-inflammatory drug, is used to relieve the inflammation, swelling, stiffness, and joint pain associated with rheumatoid arthritis and osteoarthritis.
[11] Cosopt lowers high pressure in the eye, a problem typically caused by the condition known as open-angle glaucoma. Cosopt works by reducing production of the liquid that fills the eyeball.
[12] Colchicine is used to prevent or treat attacks of gout.
[13] Miconazole cream is an antifungal type of antibiotic. Miconazole cream is used to treat fungal skin infections such as candida, ringworm, athlete's foot, and jock itch.

appropriate care provider and given appropriate care, each time he has registered any health complaints at Easterling and Bullock Correctional Facilities. (Id.)

At all times, the Defendants have exercised the same degree of care, skill, and diligence as other similarly situated health care providers would have exercised under the same or similar circumstances. (Id.) In other words, the appropriate standard of care has been adhered to at all times in providing medical care, evaluation, and treatment to this inmate. (Id.)

At no time have the Defendants denied Mr. Cammon any needed medical treatment, nor have they ever acted with deliberate indifference to any serious medical need of Mr. Cammon. (Id.) At all times, Mr. Cammon's medical complaints and conditions have been addressed as promptly as possible under the circumstances. (Id.)

III. DEFENSES

The Defendants assert the following defenses to the Plaintiff's claims:

1. The Defendants deny each and every material allegation contained in the Plaintiff's Complaint, as amended and demand strict proof thereof.

2. The Defendants plead not guilty to the charges in the Plaintiff's Complaint, as amended.

3. The Plaintiff's Complaint, as amended fails to state a claim against the Defendants for which relief can be granted.

4. The Defendants affirmatively deny any and all alleged claims by the Plaintiff.

5. The Plaintiff is not entitled to any relief requested in the Complaint, as amended.

6. The Defendants plead the defense of qualified immunity and aver that the actions taken by the Defendants were reasonable and in good faith with reference to clearly established law at the time of the incidents complained of by the Plaintiff.

7. The Defendants are entitled to qualified immunity and it is clear from the face of the Complaint, as amended that the Plaintiff has not alleged specific facts indicating that the Defendants have violated any clearly established constitutional right.

8. The Defendants cannot be held liable on the basis of respondeat superior, agency, or vicarious liability theories.

9. The Plaintiff is not entitled to any relief under 42 U.S.C. § 1983.

10. The allegations contained in the Plaintiff's Complaint, as amended against the Defendants sued in their individual capacities, fail to comply with the heightened specificity requirement of Rule 8 in § 1983 cases against persons sued in their individual capacities. See Oladeinde v. City of Birmingham, 963 F.2d 1481, 1485 (11th Cir. 1992); Arnold v. Board of Educ. Of Escambia County, 880 F.2d 305, 309 (11th Cir. 1989).

11. The Defendants plead all applicable immunities, including, but not limited to qualified, absolute, discretionary function immunity, and state agent immunity.

12. The Defendants aver that they were at all times acting under color of state law and, therefore, they are entitled to substantive immunity under the law of the State of Alabama.

13. The Defendants plead the general issue.

14. This Court lacks subject matter jurisdiction due to the fact that even if the Plaintiff's allegations should be proven, the allegations against the Defendants would

amount to mere negligence which is not recognized as a deprivation of the Plaintiff's constitutional rights. See Rogers v. Evans, 792 F.2d 1052 (11th Cir. 1986).

15. The Plaintiff's claims against the Defendants in their official capacities are barred by the Eleventh Amendment to the United States Constitution.

16. Alabama law provides tort and other remedies for the allegations made by the Plaintiff herein and such remedies are constitutionally adequate.

17. The Defendants plead the defense that at all times in treating Plaintiff they exercised the same degree of care, skill, and diligence as other physicians and nursing staff would have exercised under similar circumstances and that at no time did they act toward the Plaintiff with deliberate indifference to a serious medical need.

18. The Defendants plead the affirmative defense that the Plaintiff's Complaint, as amended fails to contain a detailed specification and factual description of the acts and omissions alleged to render it liable to the Plaintiff as required by § 6-5-551 of the Ala. Code (1993).

19. The Defendants plead the affirmative defenses of contributory negligence and assumption of the risk.

20. The Defendants plead the affirmative defense that Plaintiff's damages, if any, were the result of an independent, efficient, and/or intervening cause.

21. The Defendants plead the affirmative defense that they are not responsible for the policies and procedures of the Alabama Department of Corrections.

22. The Defendants plead the affirmative defense that the Plaintiff has failed to mitigate his own damages.

23. The Defendants plead the affirmative defense that they are not guilty of any conduct which would justify the imposition of punitive damages against them and that any such award would violate the United States Constitution.

24. The Defendants adopt and assert all defenses set forth in the Alabama Medical Liability Act § 6-5-481, et seq., and § 6-5-542, et seq.

25. The Plaintiff has failed to exhaust his administrative remedies as mandated by the Prison Litigation Reform Act amendment to 42 U.S.C. § 1997e(a). The Plaintiff has failed to pursue the administrative remedies available to him. See Cruz v. Jordan, 80 F. Supp. 2d 109 (S.D. N.Y. 1999) (claims concerning Defendant's deliberate indifference to a medical need is an action "with respect to prison conditions" and is thus governed by exhaustion requirement).

26. The Prison Litigation Reform Act amendment to 42 U.S.C. § 1997(e)(c) mandates the dismissal of Plaintiff's claims herein as this action is frivolous, malicious, fails to state a claim upon which relief can be granted, or seeks money damages from the Defendants who are entitled to immunity.

27. The Plaintiff's claims are barred by the Prison Litigation Reform Act of 1995, 42 U.S.C. §1997(e).

28. The Plaintiff has failed to comply with 28 U.S.C. § 1915 with respect to the requirements and limitations inmates must follow in filing in forma pauperis actions in federal court.

29. Pursuant to 28 U.S.C. § 1915 A, this Court is requested to screen and dismiss this case, as soon as possible, either before or after docketing, as this case is frivolous or malicious, fails to state a claim upon which relief may be granted, or seeks

money damages from the Defendants who are state officers entitled to immunity as provided for in 42 U.S.C. § 1997 (e)(c).

30. The Defendants assert that the Plaintiff's Complaint, as amended is frivolous and filed in bad faith solely for the purpose of harassment and intimidation and requests this Court pursuant to 42 U.S.C. § 1988 to award these Defendants reasonable attorney's fees and costs incurred in the defense of this case.

31. The Plaintiff's claims are moot because the events which underlie the controversy have been resolved. See Marie v. Nickels, 70 F., Supp. 2d 1252 (D. Kan. 1999).

IV. ARGUMENT

A. The Plaintiff has failed to prove that the Defendants acted with deliberative indifference to any serious medical need.

A court may dismiss a complaint for failure to state a claim if it is clear that no relief could be granted under any set of facts that could be proven consistent with the allegations in the complaint. Romero v. City of Clanton, 220 F. Supp. 2d 1313, 1315 (M.D. Ala., 2002), (citing, Hishon v. King & Spalding, 467 U.S. 69, 73, (1984). "Procedures exist, including Federal Rule of Civil Procedure 7(a), or Rule 12(e), whereby the trial court may "protect the substance of qualified immunity," Shows v. Morgan, 40 F. Supp. 2d 1345, 1358 (M.D. Ala., 1999). A careful review of Cammon's medical records reveals that Cammon has been given appropriate medical treatment at all times. (See Exhibits "A," "B," & "C"). All of the allegations contained within Cammon's Complaint, as amended are either inconsistent with his medical records, or are claims for which no relief may be granted. (Id.) Therefore, Cammon's claims against the Defendants are due to be dismissed.

In order to state a cognizable claim under the Eighth Amendment, Cammon must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. See Estelle v. Gamble, 429 U.S. 97, 106 (U.S. 1976); McElligott v. Foley, 182 F.3d 1248, 1254 (11th Cir. 1999); Palermo v. Corr. Med. Servs., 148 F. Supp. 2d 1340, 1342 (S.D. Fla. 2001). In order to prevail, Cammon must allege and prove that he suffered from a serious medical need, that the Defendants were deliberately indifferent to his needs, and that he suffered harm due to deliberate indifference. See Marsh v. Butler County, 268 F.3d 1014, 1058 (11th Cir. 2001) and Palermo, 148 F. Supp. 2d at 1342. "Neither inadvertent failure to provide adequate medical care nor a physician's negligence in diagnosing or treating a medical condition states a valid claim of medical mistreatment under the Eighth Amendment." Id. (citations omitted).

Not every claim by a prisoner that medical treatment has been inadequate states an Eighth Amendment violation. Alleged negligent conduct with regard to inmates' serious medical conditions does not rise to the level of a constitutional violation. Alleged medical malpractice does not become a constitutional violation merely because the alleged victim is a prisoner. See Estelle, 429 U.S. at 106, McElligott, 182 F.3d at 1254, Hill, 40 F.3d 1176, 1186 (11th Cir. 1994), Palermo, 148 F. Supp. 2d at 1342. Further, a mere difference of opinion between an inmate and the physician as to treatment and diagnosis cannot give rise to a cause of action under the Eighth Amendment. Estelle, 429 U.S. at 106-108.

The Defendants may only be liable if they had knowledge of Cammon's medical condition, Hill, 40 F. 3d at 1191, and acted intentionally or recklessly to deny or delay access to his care, or to interfere with treatment once prescribed. Estelle, 429 U.S. at 104-

105. Obviously, Cammon cannot carry his burden. The evidence submitted with this Special Report clearly shows that the Defendants did not act intentionally or recklessly to deny or delay medical care, or to interfere with any treatment which was prescribed or directed. The evidence demonstrates, to the contrary, that appropriate standards of care were followed at all times. (Id.) These facts clearly disprove any claim that the Defendants acted intentionally or recklessly to deny treatment or care.

The Defendants are, further, entitled to qualified immunity from all claims asserted by Cammon in this action. There is no argument that the Defendants were not acting within the scope of their discretionary authority. See Eubanks v. Gerwen, 40 F. 3d 1157, 1160 (11th Cir. 1994); see also Jordan v. Doe, 38 F. 3d 1559, 1566 (11th Cir. 1994). Because the Defendants have demonstrated that they were acting within the scope of their discretionary authority, the burden shifts to Cammon to show that the Defendants violated clearly established law based upon objective standards. Eubanks, 40 F. 3d at 1160. The Eleventh Circuit requires that before the Defendants' actions can be said to have violated clearly established constitutional rights, Cammon must show that the right allegedly violated was clearly established in a fact-specific, particularized sense. Edwards v. Gilbert, 867 F.2d 1271, 1273 (11th Cir. 1989), aff'd in pertinent part, rev'd in part on other grounds, sub nom., Edwards v. Okaloosa County, 5 F. 3d 1431 (11th Cir. 1989).

The Eleventh Circuit further requires that the inquiry be fact specific, and that officials will be immune from suit if the law with respect to their actions was unclear at the time the cause of action arose, or if a reasonable person could have believed that their actions were lawful in light of clearly established law and information possessed by the

individual. See Brescher v. Von Stein, 904 F.2d 572, 579 (11th Cir. 1990) (quoting, Anderson v. Creighton, 483 U.S. 635, 640, (U. S. 1987)). The question that must be asked is whether the state of the law in 2006 gave the Defendants fair warning that the alleged treatment of Cammon was unconstitutional. Hope v. Pelzer, 536 U.S. 730, 741 (U.S. 2002).

Therefore, to defeat summary judgment, Cammon must be able to point to cases with "materially similar" facts, within the Eleventh Circuit, that would alert the Defendants to the fact that its practice or policy violates his constitutional rights. See Hansen v. Soldenwagner, 19 F.3d 573, 576 (11th Cir. 1994). In order for qualified immunity to be defeated, preexisting law must "dictate, that is truly compel (not just suggest or allow or raise a question about), the conclusion for every like-situated, reasonable government agent that what the defendant is doing violates federal law in the circumstances." Lassiter v. Alabama A & M Univ., Bd. of Trustees, 28 F. 3d 1146, 1151 (11th Cir. 1994). The Defendants submit that there is no case law from the United States Supreme Court, the Eleventh Circuit Court of Appeals, or District Courts sitting within the Eleventh Circuit showing that, under the facts of this case, it was clearly established that these alleged actions violated Cammon's constitutional rights. All of Cammon's medical needs have been addressed or treated. (See Exhibits "A," "B," & "C"). The Defendants have provided Cammon with appropriate medical care at all times and he has received appropriate nursing care as indicated for treatment of his condition.

V. CONCLUSION

The Plaintiff's Complaint, as amended, is due to be dismissed on its face, and is, further, disproven by the evidence now before the Court. All of the Plaintiff's requests for relief are without merit. The Defendants have demonstrated both through substantial evidence and appropriate precedent that there is not any genuine issue of material facts relating to a constitutional violation, and that they are, therefore, entitled to a judgment in their favor as a matter of law. The Plaintiff's submissions clearly fail to meet his required burden.

Accordingly, the Defendants request that this Special Report be treated and denominated as a Motion to Dismiss and/or a Motion for Summary Judgment and that this Honorable Court either dismiss the Plaintiff's Complaint, as amended, with prejudice, or enter a judgment in their favor.

Respectfully submitted,

s/L. Peyton Chapman, III
Alabama State Bar Number CHA060
s/R. Brett Garrett
Alabama State Bar Number GAR085
Attorneys for Prison Health Services, Inc. and Tahir Siddiq, M.D.

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CERTIFICATE OF SERVICE

I hereby certified that I have mailed via U.S. mail, properly addressed and first-class postage prepaid, the foregoing document this 26th day of October, 2006, to the following:

LONNIE CAMMON, (AIS #236498)
Bullock Correctional Facility
P.O. Box 5107
Union Springs, AL 36089

s/R. Brett Garrett
Alabama State Bar Number GAR085
Attorney for Prison Health Services,
Inc. and Tahir Siddiq, M.D.

EXHIBIT A-1

PHS PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME:
D.O.B. / /
ALLERGIES:
Use Last Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:
D.O.B. / /
ALLERGIES:
Use Fourth Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:
D.O.B. /
ALLERGIES: 7/17/06
Use Third Date / /

noted 7/17/06

DIAGNOSIS (If Chg'd)
(1) Naprosyn 250 po bid x 15 d
(2) Prednisone 20 mg po qd x 10 d

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cannon, Lonnie
AIS 238492
D.O.B. /
ALLERGIES: 7/10/06
Use Second Date 7/10/06

noted 7/10/06

DIAGNOSIS (If Chg'd)
CBC
Myoneurol I

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:
D.O.B. / /
ALLERGIES: 7/10/6
Use First Date / /

DIAGNOSIS (1) 4 wz Bandess/ice 9 d x 3 days
(2) Percocet 1 po bid x 10 d

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

60110 (4/03)

MEDICAL RECORDS COPY

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: D.O.B. / / ALLERGIES: Use Last Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Fourth Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Third Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Second Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: [illegible] D.O.B. [redacted] ALLERGIES: Noted [illegible] 10/24/06 Use First Date / /	DIAGNOSIS 4 mg [illegible] x 1 [illegible] ☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Cammon Lonnie 238498 D.O.B. / / ALLERGIES: 6/13/06 Use Last Date / /	DIAGNOSIS (If Chg'd) May use Diapers prn for Urinary Incontinence x 30 D ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Cammon Lonnie D.O.B. / / ALLERGIES: 6/8/06 Use Fourth Date / /	DIAGNOSIS (If Chg'd) Hemorrhoidal Oint x 20 Days KOP ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Cammon Lonnie 238498 D.O.B. / / ALLERGIES: 6/2/06 noted Use Third Date / /	DIAGNOSIS (If Chg'd) Submit Fluid for Crystals (Uric Acid) ... ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Cammon, Lonnie D.O.B. / / ALLERGIES: 6/2/06 NOTED 6-2-06 NJT, RN Use Second Date / /	DIAGNOSIS (If Chg'd) ① ✓ ASA ī ... 300 ... ② ✓ Mevacor 20 mg ... ... ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Cammon Lonnie 238498 D.O.B. [redacted] ALLERGIES: NKDA 6/1/06 noted Use First Date 06/01/06	DIAGNOSIS 4 mg Medrol ... x 5 days ☐ GENERIC SUBSTITUTION IS NOT PERMITTED

60110 (4/03)

MEDICAL RECORDS COPY

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME:

D.O.B. / /

ALLERGIES:

Use Last Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B. / /

ALLERGIES:

Use Fourth Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B / /

ALLERGIES:

Use Third Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B. / /

ALLERGIES:

Use Second Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cammon, Lonnie

D.O.B. [redacted]

ALLERGIES:

Use F Date 5/9/2006

DIAGNOSIS

refer to Dr. Dannenn for BAP glaucoma evaluation

[signature] 5/9/6

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

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PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Cammon Lonnie #238498
D.O.B. [redacted]
ALLERGIES: NKDA
Use Last Date 4/5/06

DIAGNOSIS (If Chg'd) DJD, CVA
CXR
DC Prednisone
DC Feldene
Naprosyn 375 mg i po BID x 14 days
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cammon Lonnie #238498
D.O.B. [redacted]
ALLERGIES: NKDA
Use Fourth Date 3/22/06

DIAGNOSIS (If Chg'd) DDD c [illegible]
Feldene 20 mg i po QPM x 30 days
Prednisone 20 mg po BID x 5 days then 20 mg po QD x 5 days
f/u next week
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cammon Lonnie #238498
D.O.B. [redacted]
ALLERGIES: NKDA
Use Third Date 3/15/06

DIAGNOSIS (If Chg'd)
PPD
V/O Dr. Darbouze / [illegible]
☐ GENERIC SUBSTITUTION IS NOT PERMITTED 3/17/06

NAME: Cammon Lonnie
D.O.B. [redacted]
ALLERGIES: NKDA
Use Second Date 3/13/06

DIAGNOSIS (If Chg'd) [illegible] edema, [illegible]
Ace wrap L Arm
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cammon Lonnie
[redacted]
ALLERGIES: NKDA
Date 3/9/06

DIAGNOSIS Edema L Arm
lay in profile x 6 months
keep L arm elevated x 2 weeks
DP III 3/13/06
[illegible] 3/14/06
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Cammon Lonnie D.O.B [redacted] ALLERGIES: NKDA Noted [signature] Use Last Date 3/9/06	DIAGNOSIS (If Chg'd) Edema L Arm, Throm Pedis Lasix 40mg i po QD x 5 days KCl 10meq i po QD x 5 days Miconazole cr BID x 30 days Sling L ARM x 2 weeks ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: CAMMON, LONNIE #238498 D.O.B [redacted] ALLERGIES: NKDA noted 3/6/06 3 5pm Use Fourth Date 3/6/06	DIAGNOSIS (If Chg'd) EC ASA 325mg i PO qd X90 days NTG 0.4mg SL as directed PRN chest pain X90 days DITROPAN 5mg i po bid X90 days COSOPT 0.5% i gtt ea. eye bid X90 days ☐ GENERIC SUBSTITUTION IS NOT PERMITTED [signature]
NAME: Cammon Lonnie #238498 D.O.B [redacted] ALLERGIES: NKDA charted 3/3/06 [signature] 1:50pm Use Third Date 3/3/06	DIAGNOSIS (If Chg'd) Arthritis L shoulder, DDD c spine Prednisone 20mg po BID x 5 days then 20mg po QD x 5 days DC Naproxen MD next week ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Cammon Lonnie #238498 D.O.B [redacted] ALLERGIES: NKDA Use Second Date 2/28/06	DIAGNOSIS (If Chg'd) Mevacor 40 mg i po Bid X 90 days ☐ GENERIC SUBSTITUTION IS NOT PERMITTED [signature]
NAME: Cammon Lonnie #238498 D O B [redacted] ALLERGIES: NKDA 2-27-06 [signature] Use First Date 2/27/06	DIAGNOSIS X Ray of L shoulder, L elbow and L wrist C spine series Naproxen 375mg po BID prn X 14 days ☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

60110 (4/03)

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Cannon Lonnie
DIAGNOSIS (If Chg'd) D/D, Chest Pain
D.O.B [redacted]
ALLERGIES: NKDA
Noted 2/15/06 [illegible] 1140am
Naproxen 375 mg i po BID x 14 days PRN
NTG SL PRN x 100 days (0.4 mg)
DC Colchicine
Use Last Date 2/15/06
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cannon Lonnie
DIAGNOSIS (If Chg'd)
D.O.B [redacted]
ALLERGIES: NKDA
Noted [illegible] 2/7
Naproxen 375 mg i po BID PRN x 10 days (TEN)
f/u next week
Colchicine 0.6 mg po QD x 10 days
BP + P QD x 3 days
Use Fourth Date 2/7/06
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cannon Lonnie
#238498
DIAGNOSIS (If Chg'd)
D.O.B [redacted]
ALLERGIES: NKDA
1/24/06 noted [illegible]
Dc Isordil
Bengay BID PRN x 5 days
Use Third Date 1/24/06
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cannon Lonnie
DIAGNOSIS (If Chg'd)
D.O.B [redacted]
ALLERGIES: NKDA
BP + P QD x 3 days
f/u 2 weeks
Use Second Date 1/23/06
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cannon Lonnie
#238498
DIAGNOSIS chest pain, Arthralgia - Tinea Cruris
D.O.B [redacted]
ALLERGIES: NKDA
noted [illegible] 1-23-06
↑ Isordil to 10 mg i po TID x 90 days
Tylenol 1g i po TID PRN x 90 days
Miconazole cr to inguinal area BID x 14
Feldene 20 mg i po QPM x 5 days
Use First Date 1/23/06
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Cammon, Lonnie

D.O.B. [redacted]

ALLERGIES: NKDA

Noted H9-cle COWRN

Use Last Date 1/19/06

DIAGNOSIS (If Chg'd)

Release to DOC - Return PRN
NTG sublingual PRN chest pain
Isordil 5mg i po TID x 90days

☐ GENERIC SUBSTITUTION IS NOT PERMITTED TO Dr Darbouze | [illegible]
1/23/06

NAME: CAMMON, LONNIE
238498

D.O.B. [redacted]

ALLERGIES: NKA

noted SBN 1-13-06

Use Fourth Date 1/13/06

DIAGNOSIS (If Chg'd)

EC ASA 325mg i PO qd x 90 days
Altace 5mg i PO BID x 90 days
Mevacor 40mg i PO BID x 90 days
V.O. Dr. Darbouze / [illegible]

☐ GENERIC SUBSTITUTION IS NOT PERMITTED 1/13/06

NAME: Cammon Lonnie

D.O.B. [redacted]

ALLERGIES: NKDA

Noted [illegible] 1/3/06

Use Third Date 1/3/06

DIAGNOSIS (If Chg'd) Dyspepsia

Zantac 150mg i po BID x 90 days

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cammon, Lonnie
238498

D.O.B. [redacted]

ALLERGIES: NKA.

Noted [illegible] 12/31/05

Use Second Date 12/31/05

DIAGNOSIS (If Chg'd)

Cosopt 0.5% i gtt each eye bid

☐ GENERIC SUBSTITUTION IS NOT PERMITTED VO Dr Darbouze / [illegible]
1/2/05

NAME: Cammon Lonnie

D.O.B. [redacted]

ALLERGIES: NKDA

noted SB 11/29/05

Use First Date 11/29/05

DIAGNOSIS

Cane Profile KOP

V/O Dr. Darbouze / SBush LPN

☐ GENERIC SUBSTITUTION IS NOT PERMITTED [illegible] 11/29/05

MEDICAL RECORDS COPY

60110 (1/03)

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Cammon, Connie
D.O.B [redacted]
ALLERGIES: NKA
Use Last Date 11/19/05

DIAGNOSIS (If Chg'd)
Motrin 400mg po bid x 3 days

☐ GENERIC SUBSTITUTION IS NOT PERMITTED V.O. Dr. Darbouze

NAME: Cammon Lonnie 238498
D.O.B. [redacted]
ALLERGIES: NKDA
Use Fourth Date 11/7/05

noted 11/7/05

DIAGNOSIS (If Chg'd) D/D. CVA 11/21/05

DC Percogesic
Tylenol 1g po BID prn x 90 days

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cammon Lonnie
D.O.B [redacted]
ALLERGIES: NKDA
Use Third Date 10/25/05

noted

DIAGNOSIS (If Chg'd) Tinea Cruris, D/D.

Miconazole cr to inguinal area BID x 14 days KOP
DC Tylenol
Percogesic ii po TID prn back/shoulder pain x 90 days

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cammon Lonnie
D.O.B [redacted]
ALLERGIES: NKDA
Use Second Date 8/25/05

noted 8/25/05

DIAGNOSIS (If Chg'd)

BP ↑ (fasting) in 6 weeks

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cammon Lonnie
D.O.B [redacted]
ALLERGIES: NKDA
Use First Date 8/25/05

DIAGNOSIS CVA, D/D, voiding incontinence

EC ASA 325mg i po QD x 180 days
Ditropan 5mg i po BID x 180 days
Mevacor 40mg i po BID x 180 days
Tylenol 1g po BID prn x 90 days

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

60110 (4/03)

PHS

PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: D.O.B.: / /
6/28/06 [illegible]	S) C/o having pain to the (L) arm
	O) [illegible] arm [illegible] & pain to the arm
	[illegible] will give Advil [illegible]
7/10/06	S) (L) arm swelling
	O) Chronic swelling to Elbow arthritis now much better. good ROM.
	x Ray [illegible] normal.
7/17/06 [illegible]	S) (L) forearm swelling
	O) Elbow arthritis c̄ effusion swelling around forearm & Elbow.
	slight tenderness
	A) Elbow arthritis
	P) will [illegible] Naprosyn & [illegible] [signature]

PHS
PRISON
HEALTH
SERVICES
INCORPORATED

Cammon, Connie

PROGRESS NOTES

Date/Time	Inmate's Name: D.O.B.: / /
6/1/6	S/ (L) arm swelling & slight pain
	O/ swelling to (L) arm x 6 mo
	x-rays normal
	tender to touch around
	elbow
	good pulses
	A/ swelling of arm ? , axillary vein thrombosis, r/o gout
	P/ I will give Indocin for few days to see
	if swelling + if not will do
	f/u
6/12/6	S/ (L) arm swelling, pain to elbow
	O/ Elbow showing fluctuation
	Fluid removed - clear
	non purulent fluid.
	I/A Decadron given
	A/ Bursitis (Gout)
	P/ will submit for analysis, and continue
	1/2 Indocin 1/2 every day

Date/Time	Inmate's Name: D.O.B.: [redacted]
3/23	Wt 140 BP 102/60 P 70 R 16 T 99.1
	Rectal
	DRE: No Hemorrhoids, no Mass
	Good sphincter tone
	Prostate normal
	Stool yellow – Hemoccult negative.
3/29/06	Wt 142 B/P 100/60 P-82 R-16 T
	F/U O2Sat 97/90
4/5/06	Wt. 145 B/P 140/70 P-72 R16 T-97.4
S	S/C 78 y/o c/o being tired of walking long distance to eat and take the medications. c/o R sided weakness from CVA, urinary incontinence – Request for Transfer to Kilby C.F.
O	NAD, VSS Heart: RRR
	Lung: CTA Ext: + Ordema in the arm up to the shoulder, + tenderness
	Neuro: 5+ 5+ 4+ 5+ over the elbow to the wrist
	mild Atrophy
A/P	CVA, Urinary Incontinence, DJD.
	Rx: DC Prednisone, Lasix + KCl QD x/8 days
	– consider transfer to Kilby or Hamilton A/I
	– CXR
5/2/06	CCC completed Sueshect for Sonpee Haylcamp

Date/Time	Inmate's Name: Cannon Lonnie D.O.B.: / /
3306	140# 80 16 110/70 97.8
	S<
S	78 BM c/o Pain L Arm + swelling x few weeks -
	h/o DJD s/p R/L shoulder and c spine surgery
O	C spine : + old healed surgical scar, mild ↓ ROM, painful
	L elbow : ⊄ edema / tenderness, ROM full + pain
	Xray of c spine : severe DDD
	Xray L elbow : WNL
A/P	DDD c spine - pain L elbow + radiculopathy c spine
	P: Refer of Prednisone.
	Keep L Arm elevated
	f/u 1 week
2/9/06 S	Pt is here for f/u edema of his L Arm.
	Also c/o sores over R.S buttock -
O	NAD, BP: 130/80 P: 64 R: 16 T: 98°
	Lungs: CTA Heart: RRR
	chest: normal
	L Arm : + 2 pitting edema L forearm and L wrist
	+ 1 L Arm
	Skin : normal, no erythema, ⊄ warmth.
	Lower ext: ⊄ edema [+ Tinea Corporis]
A/P	Edema L Arm, Tinea Corporis
	P: - Lasix + KCl x 5 days.
	- BP III
	- Miconazole 2% cr
	- f/u next week

Date/Time	Inmate's Name: Cannon Lonnie D.O.B.: [redacted]
1/24/06 S	47 BM [illegible] today c/o pain L in shoulder and in
	upper back - h/o c-spine surgery years ago
	h/o Headache [illegible] 20 [illegible]
O-	NAD, BP: 102/60 P, 88
	Lungs: CTA Heart: RRR
	c-spine: non tender, ROM ↓ painful
	chest: + tenderness L paraspinal muscles, L shoulder, L elbow
	and L wrist
A/P	c spine radiculopathy [illegible]
	Rx: [illegible]
	[illegible]
2/7/06 1p	WT - BP 158/92 P-62 R 95?
	Chest pain Bodychart
S	47 BM c/o pain L Arm, L chest, R hip, R leg.
	h/o D/D previously on Lortab for Pain control
O-	NAD, VSS
	Lungs: CTA Heart: RRR
	chest: + L chest wall tenderness (moderate.
	L Arm: mild edema, + tenderness of the L elbow
	and wrist
	C spine: non tender, ROM good, no pain.
	old healed surgical scar
	Neuro: intact EKG: NSR no ST/T Δ
A/P	D/D → Acute Arthritis
	Rx: Naproxen, CO
	Trial of colchicine.
	f/u 1 week

Date/Time	Inmate's Name: Cammon, Lonnie D.O.B. [redacted]
12/21/05 8A	WT - 138 BP 110/68 P 78 R 16 T 96.6
	S/c pain back + (R) side
S	77 y/o BM c/o back pain → R leg worse with exertion/walking
	pt is requesting to be transferred to KCF
O -	NAD, VSS
	Lungs: CTA Heart: RRR
	Abd: benign. Ext: no edema
	L spine: non tender
	ROM: ↓, painful
	Neuro: intact
[illegible]	
A	LBP
	Plan: continue Pain[illegible], Walking cane
	Refer to DOC for ? Transfer.
1/3/06 9:30 AM	S/c WT 139 B/P 118/60 R 16 T 97.8 O2 Sat 97%
S	77 y/o BM h/o cataract OS > OD is requesting for evaluation by the eye doctor. Pt is also c/o epigastric burning
O.	NAD, VSS
	Lung: CTA Heart: RRR
	6) 14 44 (95 / 15.
A	Cataract OS>OD, Dyspepsia
	Plan: - Opt. Optometry
	- Zantac 150 BID .

Date/Time | **Inmate's Name:** Cammon, Lonnie | **D.O.B.:** [redacted]

10/12/05 8Am WT-135# BP 110/80 P 62 R 18 T 96.8

Bodychart
S/C: Pain under both arm & Chest

10/25/05 12:25p Wt. 137 140/90 P 68 R 16

Sat 98% RA

S> 77 BM c/o chronic pain both arms/shoulder, lower back and legs - rash between legs. Has no dysphagia, SOB, dizziness - was previously on Lortab for chronic pain.

O- NAD, VSS

Lungs: CTA   Heart: RRR

C-spine: old healed surgical scar, + tenderness with ↓ ROM

L-spine: + scoliosis and tenderness

ROM: ↓, painful

Neuro: No focal deficit

Skin: mild scaly hyperpigmented rash at the inguinal area

A/P DJD mult. joints, Tinea Cruris,

Rx: - DC Tylenol, [illegible]

- Miconazole cr BID

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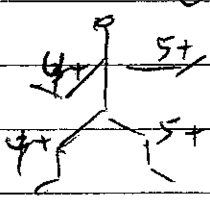
PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Cammon, Lonnie D.O.B.: [redacted]
8/25	Ht 128 BP 104/70 P 72 R 17 T 96.8
	new inmate
>	77 BM - [illegible] [illegible] [illegible]
	- CVA [illegible] [illegible] since 1986 LDL :167
	- Bladder [illegible] HDL :31
	Tot chol : 218/101
O	- NAD, VSS 139 / 19 / 79 ; 4.4 / 1.2
	[illegible] : [illegible] [illegible] EKG : NSR 53/m Hgb : 14.7
	[illegible] [illegible] [illegible]
	Lungs : CTA [illegible] : [illegible]
	[illegible] [illegible] [illegible] [illegible]
	[illegible] : A.O. [illegible] [illegible]
	[illegible] 4+
	
A/P	CVA [illegible] / [illegible] / [illegible] [illegible] / D/D
	[illegible] - ASA, [illegible] .
	- [illegible] [illegible] BID .
	- Tylenol / [illegible]
	[signature]

60111 (5/85) Complete Both Sides Before Using Another Sheet

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PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time | **Inmate's Name:** Cammon Lonnie | **D.O.B.:** [redacted]

11/17/05 Wt. 135 B/P 120/70 P- 63 R 16 T 97

back pain CCC

S 77 BM c/o Lower back pain - h/o CVA R weakness

O- NAD, VSS Breast: [illegible]

Lung: CTA Heart: S1 S2 reg ∅ m/g/R

Abd: soft Ext: ∅ [illegible] (LDL: 90 HDL: 31)

Neuro: A.O. x3, CNs intact.

Strength +4 +5 +5 +4 good coordination/equal [illegible]

(140/14 [illegible] 4.1/1.1)

A/P L spine: non tender - ROM ↓, painful

CVA - stable

HLD Plan: Tylenol trial, continue current Tx

- daily aerobic exercise, ↓ salt/fat intake

60111 (5/85) Cc[illegible]te Both Sides Before Using Another Shee

PHS
PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Cammon, Lonnie D.O.B.: [redacted]
1-23-06 9am	WT. 139 BP 110/80 P 84 R 20 T 97.8
	O2 Sat 94%
S	77 y/o c/o pain to body to multiple joints (L shoulder,
	elbow, wrist, lower back - swollen in [illegible]. Denies
	diaphoresis, SOB, palpitation, dizziness, nausea - the pain does
	not change with rest/exertion/food intake
O	NAD, [illegible]
	Lung: CTA Heart: RRR
	Chest: + tenderness over the L paraspinal muscles.
	+ tenderness over the L elbow, L wrist,
	+ tenderness over the L spine - no deformity
	[illegible]
	EKG: NSR 69/m. no ST/T Δ. LDL: [illegible] HDL: 31
A/P	Arthralgia multiple joints, CVA, CAD
	Rx: - Tylenol ~~[illegible]~~ [illegible], Feldene QD x 5 days
	- ↑ [illegible] to 10 mg TID.
	- [illegible] ✓

60111 (5/85) [illegible]mplete Both Sides Before Using Another [illegible]et

PHS
PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Cannon Lonnie D.O.B.: [redacted]
2/15/06	Wt 142 BP 100/72 P 74 R 14 T 97°
S	[illegible] pain to multiple joints, L arm and R/L chest - States to be better compare to 2 weeks, [illegible]
	[illegible] laughing / talking
O	[illegible]
	Lungs: CTA [illegible]
	[illegible] trace of edema L Arm.
	tenderness L wrist, L elbow.
Alpha	[illegible]
	Rx: continue Rx Naproxen x 14 days
3/1/06	Wt. 142 B/P 130/80 P-80 R-16 T 97.4
	S/C

60111 (5/85)

[Co]mplete Both Sides Before Using Another S[hee]t

PHS
PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Cannon Lonnie D.O.B.: [redacted]
3/13/06 8:30 am	F/U
	Wt 140 B/P 104/60 P 68 R 18 T 97
S	[illegible] edema [illegible] Arm. No pain.
	[illegible] over his chest with his arm under his
	head
O	NAD [illegible]
	lungs CTA heart [illegible]
	[illegible] arm: + soft [illegible] edema
	no erythema, no tenderness
A/Plan	[illegible] edema [illegible] Arm
	Plan: Ace wrap [illegible] arm
	[illegible]
	Avoid sleeping over the [illegible] arm

Date/Time	Inmate's Name: D.O.B.: / /
6/8/06	S) Anal irritation
	O) Skin around anus
	excoriated
	[illegible]
	no [illegible]
	A) Excoriation of skin
	P) will give Hemorrhoidal Cream
6/13/06	S) I can't hold my urine
	O) Sometimes he stays incontinent of
	urine
	His BM is good
	A) Urinary incontinence
	P) will give Depends + F/U

Date/Time	Inmate's Name: D.O.B.: / /
7/17/06	S) 108 Elbow Pain
	8) mild Effusion to Elbow
	Swelling & Forearm
	Report Pain
	A) Arthritis
	P) will give Quel Medrol in the Elbow Joint

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 7-24-06
ID # 238498 Date of Birth: [redacted] Location: 16-24
Nature of problem or request: CAN'T Hold Water or Urine!

Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment: Waiver Signed 7/26/06

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Nursing Evaluation Tool: General Sick Call

Patient Name: Cannon, Lonnie (Last, First)
Inmate Number: 238498
Date of Birth: [redacted] (MM DD YYYY)
Date of Report: 7/17/06 (MM DD YYYY)
Time Seen: 0600 AM / PM Circle One

Subjective: Chief Complaint(s): "My whole side is swelling."
Onset: Chronic
Brief History: (Continue on back if necessary) Pt c/o swelling to whole L side of body

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98 P: 98 RR: 20 B/P: 140/100 WT 136

Examination Findings: (Continue on back if necessary)

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s): Alteration in comfort

☐ Referral NOT REQUIRED

☑ Referral REQUIRED due to the following: (Check all that apply)

☑ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☑ Instructions to return if condition worsens.

☑ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up ☑ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe)

OTC Medications given ☑ NO ☐ YES (If Yes List):

Referral: ☐ NO ☑ YES (If Yes, Whom/Where): Date for referral: 7/17/06 (MM DD YYYY)

Referral Type: ☑ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time 0600

x [signature] RN

Name: Katherine Tyler, RN

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 7/14/06
ID # 238498 Date of Birth: [redacted] Location: 16-24
Nature of problem or request: Whole left side/arm swollen & very painful left side of body hurts.

Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

INMATES MEDICAL FILE
INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS

Nursing Evaluation Tool: General Sick Call

Facility: BBB

Patient Name: Cannon (Last) Lonnie (First) MI

Inmate Number: 238498

Date of Birth: [redacted] (MM DD YYYY)

Date of Report: 7 / 7 / 06 (MM DD YYYY)

Time Seen: 0535 AM / PM Circle One

Subjective: Chief Complaint(s): "I'd Need some attention to my left

Onset: arm its hurting and swollen"

Brief History:
(Continue on back if necessary)

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98.6 P: 82 RR: 18 B/P: 130/90 Wt. 13

Examination Findings:
(Continue on back if necessary)

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

☐ Referral NOT REQUIRED

☐ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☐ NO ☑ YES (If Yes, Whom/Where): Dr. Siddiq Date for referral: 7 / 7 / 06 (MM DD YYYY)

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

x Maria Rogers

Name:

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 7/6/06
ID # 238498 Date of Birth: [redacted] Location: 23-14
Nature of problem or request: I need attention to my left arm. It is hurting and swolen very bad. Also my whole left side is bothering me.

Thank you
Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: _____ **P:** _____ **R:** _____ **BP:** _____ **WT:** _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Ronnie Cannon Date of Request: 6/23/06
ID # 238498 Date of Birth: [redacted] Location: 23-14
Nature of problem or request: left Arm blown up beyond proportion
lot of pain in arm & left side of body

Signature

DO NOT WRITE BELOW THIS LINE

Date: ____/____/____
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective: Refused Signed

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS

Nursing Evaluation Tool: General Sick Call

Facility: BBB

Patient Name: Common (Last) Lonnie (First)

Inmate Number: 238498

Date of Birth: [redacted] (MM DD YYYY)

Date of Report: ___/___/___ (MM DD YYYY)

Time Seen: 0530 AM / PM Circle One

Subjective: Chief Complaint(s): My left side + left Arm hurt

Onset: _____

Brief History: Cellulitis D Arm, Cardio
(Continue on back if necessary)

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98.4 P: 80 RR: 20 B/P: 110/80 WT 13

Examination Findings: Swelling to left Arm, Resps Regular + even Skin w/d to touch
(Continue on back if necessary)

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s): _____

☐ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☒ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: _____ (Describe)

OTC Medications given ☒ NO ☐ YES (If Yes List): _____

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr Siddiq Date for referral: 6/21/06 (MM DD YYYY)

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____ Time _____

x Martha Jackson Name: Martha Jackson LPN

PHS

Nursing Evaluation Tool: General Sick Call

Facility: BBB

Patient Name: Cannon (Last) Lonnie (First) MI

Inmate Number: 238498 Date of Birth: [redacted] (MM DD YYYY)

Date of Report: 6 / 16 / 06 (MM DD YYYY) Time Seen: _____ AM / PM Circle One

Subjective: Chief Complaint(s): "I can't hold my water, I need something for my bladder"

Onset:

Brief History: (Continue on back if necessary)

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98.6 P: 72 RR: 16 B/P: 110 180 Wt. 13

Examination Findings: (Continue on back if necessary)

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

☐ Referral NOT REQUIRED

☐ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☐ NO ☑ YES (If Yes, Whom/Where): Dr. Siddiq Date for referral: 6 / 16 / 06 (MM DD YYYY)

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

x Gloria Rogers LPN Name:

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 6/16/06
ID # 238498 Date of Birth: [redacted] Location: 23-14
Nature of problem or request: I need Something For My bladder

Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS

Nursing Evaluation Tool: General Sick Call

Facility: BBB

Patient Name: Cannon (Last) Connie (First) MI

Inmate Number: 238498

Date of Birth: [redacted] (MM DD YYYY)

Date of Report: 6 / 13 / 06 (MM DD YYYY)

Time Seen: 5 AM / PM Circle One

Subjective: Chief Complaint(s): I'm having Excessive sweating & have Arthritis

Onset:

Brief History: (Continue on back if necessary)

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97 P: 92 RR: 18 B/P: 112 / 60 wt 138

Examination Findings: (Continue on back if necessary) (2) Arm swelling - frequent urination

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

☐ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply)

☒ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): DR Sibley Date for referral: 6 / 13 / 06 (MM DD YYYY)

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

x

Name: V Slaka

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 6-12-06
ID # 238498 Date of Birth: [redacted] Location: 23-14
Nature of problem or request: Need to see doctor about urinating excessively. And I have arthritis in my back.

Thank you

Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

DEPARTMENT OF CORRECTIONS

TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record
Institution: BCCC
Date: 6/2/06 Time: 0919 AM/PM
RECEIVED FROM:
Institution/Work Release Center/Free-World Hospital

RECEIVING MEDICAL STATUS
- [x] Population
- [ ] Infirmary
- [ ] Isolation

RELEASED: Inmate/Health Record
Institution: EASTERLING
Date: 5-31-06 Time: 6:00 AM/PM
RELEASE FROM:
- [ ] Infirmary
- [ ] Segregation
- [x] Population
- [ ] Mental Health
- [ ] Other

RELEASE TO:
- [x] DOC
- [ ] Infirmary
- [ ] Mental Health
- [ ] BULLOCK CORR.

Institution/Work Release Center/Free-World Hospital

ALLERGIES:
NKDA

PHYSICAL EXAMINATION
Date of last exam: 3-15-06
Chest X-Ray Date: 4-5-06 Result: NEG
PPD Reading 3-18-06 NEG
Classification: NONE
Limitations:

LAB RESULTS - - LAST REPORT

	Date	Normal	Abnormal
CBC	3-13-06	[ ]	[x]
Urinalysis	3-17-05	[x]	[ ]
		[ ]	[ ]

	YES	NO
Wears Glasses/Contacts	[x]	[ ]
Dental Prosthesis	[x]	[ ]
Hearing Aide	[ ]	[x]
Other Prosthesis	[ ]	[ ]

Recieving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS
DJD - MULTIPLE JOINTS
Hx CVA
BLADDER INCONTINENCE
GLAUCOMA
CATARACTS

CURRENT MEDICATION - - DOSAGE AND FREQUENCY
SW
MAV

MEDICATIONS	[x] Sent w / inmate	[ ] Not sent w / inmate
X-RAY FILM	[ ] Sent w / inmate	[ ] Not sent w / inmate
HEALTH RECORD	[x] Sent w / inmate	[ ] Not sent w / inmate

Released to: DOC
Date: 5-31-06 Time: 6:00 AM/PM

MEDICATIONS	[ ] Received	[ ] Not Received
X-RAY FILM	[ ] Received	[ ] Not Received
HEALTH RECORD	[ ] Received	[ ] Not Received
CHART REVIEWED	[ ] YES	[ ] NO

Received by: Signature of Receiving Nurse
Date: 6/2/06 Time: 0910 AM/PM

SCHEDULE FOR CHRONIC CARE CLINIC
DATE: 5-2-06 LAST CLINIC: CARDIO

FOLLOW-UP CARE NEEDED

	Date	Time	With Whom - - Location (Sending Nurse)	Date/Appt Made w/Whom (Rec. Nurse
[x] Medical				
[ ] Dental				
[ ] Mental Health				

NURSING ASSESSMENT (SENDING NURSE) (Noted from health record documentation)

		Yes	No
HISTORY	Drug Use		✓
	Mental Illness		✓
	Suicide Attempt		✓
	Chronic Care	✓	
STATUS	Special Diet		✓
	Appearance	NML	

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE) (Noted from inmate assessment)

		Yes	No
SKIN	Open Sores		✓
	Lice		✓
	Edema	✓	
	Warm & Dry		✓
	Cool & Moist		✓
CONDITION	Alert	✓	
	Oriented	✓	
	Uncooperative		✓
	Depressed		✓

INTAKE

Sick Call Procedures Explained	Yes
Height	5'7
Weight	142
Blood Pressure	160/60
Temperature	98
Pulse Resp	68/20
Other	

J. [illegible]
Signature of Nurse Completing Assessment (Sending Nurse)

5-31-06
Date

Signature of Intake Screening Nurse (Receiving Nurse)

Date

INMATE NAME (LAST FIRST MIDDLE)	DOC#	DOB	Race/Sex	FAC
CAMMON, CONNIE	238488	[redacted]	B/M	ECF

PHS

Nursing Evaluation Tool: General Sick Call

Facility: BBB

Patient Name: Hammon Lonnie (Last, First, MI) NKDA

Inmate Number: 238498

Date of Birth: 02 (MM) 20 (DD) 1938 (YYYY)

Date of Report: 05 (MM) 31 (DD) 06 (YYYY)

Time Seen: 1445 AM / PM (Circle One)

D/C'd

Subjective Chief Complaint(s): "My (D) arm is swollen"

Onset: "started about 2 months ago @ Easterling"

Brief History: (Continue on back if necessary) Has Hx Back Surgery (1965 & before), CVA (About 1965), DJD-Multiple Joints, Glaucoma both eyes, Cataract (D) eye, Cellulitis (D) arm (5/2/06), Urinary incontinence

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 96.6/oral P: 72 RR: 22 B/P: 106 / 68

Examination Findings: (Continue on back if necessary) Alert, oriented, skin W & D to touch, color normal, resp. regular & unlabored, amb. c steady gait - (D) arm grossly swollen from shoulder all the way down, skin tight & shiny, has good flash back to nailbeds - Unable to palpate pulse (D) hand - Unable to close (D) hand into fist - states pain abt 5" on scale 1-10 - States pain increased when arm is bent or straightened

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s): Alteration in ROM (D) arm r/t swelling

☐ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply) Alteration in comfort r/t pain, swelling (D) arm

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☒ Other: Arm grossly swollen.

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☒ Instructions to return if condition worsens.

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☒ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr. T. Siddiq Date for referral: / / (MM DD YYYY)

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

x Name:

PHS
PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 5/30/06 TIME 730 AM (PM)
ORIGINATING FACILITY ECF ☐ SIR ☐ PDL ☐ ESCAPEE ☐
☒ SICK CALL ☐ EMERGENCY ☐ OUTPATIENT

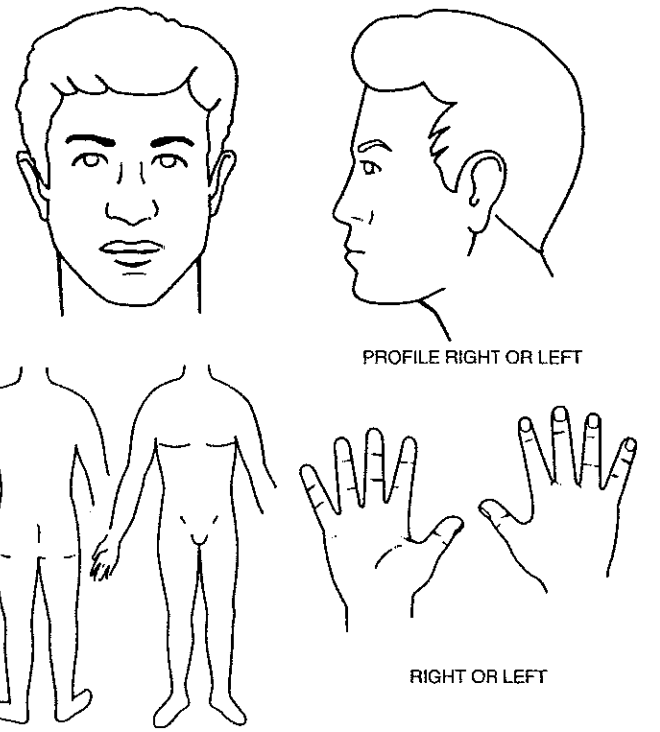
ALLERGIES NKDA
CONDITION ON ADMISSION ☒ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 98.8 ORAL / RECTAL RESP 20 PULSE 88 B/P ___/___ RECHECK IF SYSTOLIC <100> 50 ___/___

NATURE OF INJURY OR ILLNESS

S "My arm has been like this for 5 months."
O Alert elderly B/M. L arm considerely larger than Right. Warm to touch. Cap refill <3.

ABRASION /// CONTUSION # BURN xx xx FRACTURE Z Z LACERATION / ___ SUTURES



PHYSICAL EXAMINATION

A: Alt in skin integrity.
P: Give motrin keep arm ↑ X3 days. See PR.

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY
Motrin 600mg	730	ES

DIAGNOSIS Swelling to (L) arm.

INSTRUCTIONS TO PATIENT Keep arm (L) elevated.

DISCHARGE DATE 5/30/06 TIME AM PM
RELEASE / TRANSFERRED TO 1 ☒ DOC ☐ AMBULANCE ☐
CONDITION ON DISCHARGE ☒ SATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL

NURSE'S SIGNATURE Elizabeth Sgn DATE 5/30/06
PHYSICIAN'S SIGNATURE DATE
CONSULTATION

INMATE NAME (LAST FIRST MIDDLE)	DOC#	DOB	R/S	FAC
Crenmon Lonnie	237498 [redacted]		B/M	ECF

PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Cammon, Lonnie 238498 D.O.B.: [redacted]
3/3/06 1400	Recd @ Bullock c Vel Fo I. Had meds and mar. Meds are as follows: Mevacor 40mg x 58, and Nitropan 5mg x 54. — J Howard mac-

PHS
PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 4/17/06
ID # 238498 Date of Birth: [redacted] Location: 78/30
Nature of problem or request: Need to see eye doctor about cataract in my eyes. Can't see out of left eye

Signature

DO NOT WRITE BELOW THIS LINE

Date: 4/18/06
Time: 145 AM PM (PM circled)
Allergies:

RECEIVED
Date: 4-18-06
Time:
Receiving Nurse Intials ______

(S)ubjective: See net tool dated 4-18-06

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan: X Lonnie Cammon

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

Nursing Evaluation To Eye Pain/Complaint

PHS

Facility: Alabama Department of Corrections

Patient Name: Cammon, Lonnie (Last, First, MI)

Inmate Number: 238498 Date of Birth: [redacted] (MM DD YYYY)

Date of Report: 4 / 18 / 06 (MM DD YYYY) Time Seen: 145 AM / PM (Circle One)

Subjective:

Chief Complaint: (Check All That Apply)

- ☐ Foreign body: ☐ Right side ☐ Left side Foreign body type: _____ or ☐ Unknown
- ☐ Change in vision: ☐ Right side ☐ Left side ☐ Blurred ☐ Decreased
- ☐ Eyelid Complaint: ☐ Right side ☐ Left side (Describe Below)
- ☐ Trauma: ☐ Right side ☐ Left side (Describe Below) Trauma sustained in altercation with custody staff, or other inmate? ☐ NO ☐ YES (Requires notification of correctional staff)
- ☐ Conjunctivitis: ☐ Right side ☐ Left side
- ☐ Seeing spots / flashes / floaters: ☐ Right side ☐ Left side
- ☐ Request for glasses: ☐ No other visual complaint Prior History of glasses? ☐ NO ☑ YES Last time seen by optometrist: _____

Associated Symptoms / Additional Eye History

- ☐ Pain: ☑ NO ☐ YES Pain Scale: (1-10)_____ Pain Description: _____ (Dull, Aching, Burning, Stinging, etc.)
- Tetanus Toxoid Within 10 years: ☑ YES ☐ NO Recent eye surgery ☑ NO ☐ YES
- Conjunctivitis symptoms: ☐ Hay fever / Allergies ☐ Itchy ☐ Redness ☐ Watery ☐ Redness ☐ Discharge: _____
- History of Glaucoma?: ☐ NO ☑ Yes (taking glaucoma medications? ☑ YES ☐ NO Cataracts ☐ NO ☑ YES
- History of Retinal Detachment?: ☑ NO ☐ Yes (_____)
- History of trauma: ☑ NO ☐ YES Type: ☐ Blunt ☐ Penetrating ☐ Chemical ☐ Other: _____

Onset: X "a few months"

History: States "I can't see out of my left eye. I've got cataracts." (Continue on back if necessary)

Objective:

Vital Signs: (As Indicated) T: 98° P: 84 RR: 20 B/P: 124 / 164

Visual acuity: R 20/50 c and 3 glasses L [illegible] "can't see chart." c and 3 glasses (If patient wears corrective lenses acuity should be checked with and without wearing corrective device)

Periorbital Exam: ☑ Normal ☐ Swelling ☐ Evidence of Infection ☐ Bruising ☐ Other: _____

Eye Exam:	Normal Findings	Abnormal Findings
Pupil:	☑ PERRL	☐ Pupil unequal/abnormal: _____
Conjunctiva:	☑ Conjunctiva pink	☐ Conjunctiva Pale ☐ Red ☐ Discharge _____
Sclera:	☑ Sclera white	☐ Yellow ☐ Red
Foreign body:	☑ No Foreign body	☐ Foreign body
Eyelid:	☑ Normal	☐ Red/Discolored ☐ Injury/Lesion ☐ Scaly ☐ Inflamed at margin ☐ Hematoma ☐ Drainage: _____ ☐ Sty

☐ Additional Examination: _____ (Continue on back if necessary)

Assessment: (Referral Status)

Preliminary Determination(s): _____

☐ Referral NOT Required — Expedited referral to a clinician except for: isolated itching with normal visual activity or glasses request only.

☑ Referral Required

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan:

Check All That Apply: ☐ Irrigate with sterile H_2O or Normal Saline, check for foreign body or abrasion, antibiotic ointment and patch x 24 hrs ☑ Instructions on care/treatment of conjunctivitis ☑ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up ☑ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits) ☐ Instructions to return if condition worsens. ☐ Other: _____ (Describe)

OTC Medications given ☑ NO ☐ YES (If Yes List): _____

Referral: ☐ NO ☑ YES (If Yes, Whom/Where): Eye MD Date for referral: 4/18/06

Referral Type: ☑ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____ Time _____

x C Wambles RN (Nurses Signature) Name: C Wambles RN (Printed) / /

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 3-16-06
ID # 238498 Date of Birth: [redacted] Location: 7-B-30
Nature of problem or request: I have a eye that is swollen and cant see out of it. I think its infected.

Signature

DO NOT WRITE BELOW THIS LINE

Date: 4/17/06
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective: Waiver No show s/c

(O)bjective **(V/S):** T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PHS
PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 3/27/06
ID # 228498 Date of Birth: [redacted] Location: 7830
Nature of problem or request: Need to see the Doctor about a Medical transfer

Signature

DO NOT WRITE BELOW THIS LINE

Date: 4/2/06
Time: 200 AM PM
Allergies:

RECEIVED
Date:
Time:
Receiving Nurse Intials ______

(S)ubjective: See Net tool enorcw ~~Waiver~~ dated 4-2-06 AW/PA

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan: Lonnie Cammon

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PHS

Nursing Evaluation Tool: General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Cammon, Lonnie
Last First MI

Inmate Number: 238498 Date of Birth: [redacted]
MM DD YYYY

Date of Report: 4 / 12 / 06 Time Seen: 2:00 AM / PM (circled: PM) Circle One
MM DD YYYY

Subjective: Chief Complaint(s): "I need to be transferred to Kilby"

Onset: "every since I've been here."

Brief History: states "I can't do all this walking around here."
(Continue on back if necessary)

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98.2 P: 74 RR: 16 B/P: 112 / 74

Examination Findings: B/m A+O x3 Resp even + unlabored. Skin warm + dry to touch. Hx CVA (L) weakness and states would like to be transferred to Kilby.
(Continue on back if necessary)

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

☐ Referral NOT REQUIRED

☑ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☑ Other: unresolvable by nurse.

Noted [signature] 4/13/06

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☑ Instructions to return if condition worsens.

☑ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☑ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: ____________
(Describe)

OTC Medications given ☑ NO ☐ YES (If Yes List):

Referral: ☐ NO ☑ YES (If Yes, Whom/Where): Dr Darbouze Date for referral: 4/14/06
MM DD YYYY

Referral Type: ☑ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

CWambles RN
Nurses Signature

Name: CWambles RN

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 2/23/06
ID # 238498 Date of Birth: [redacted] Location: 7-B-60
Nature of problem or request: Id like to see the Doctor

_____

_____

_____

_____
Signature

DO NOT WRITE BELOW THIS LINE

Date: ____/____/____
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective **(V/S):** T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

Lonnie Cammon
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PHS

Nursing Evaluation Tool: Chest Pain

Facility: Alabama Department of Corrections

Patient Name: CAmmon (Last) Lonnie (First)

Inmate Number: 238498 Date of Birth: [redacted] (MM DD YYYY)

Date of Report: 02 / 05 / 2006 (MM DD YYYY) Time Seen: 900 AM / PM Circle One

Subjective: Chief Complaint(s): "I have been hurting in my Chest & down my arm all

Onset: 12:30 PM 2/4/06 Activity prior to onset: NONE None

History: CVA 1986 Right Side Weakness
(Continue on back if necessary)

☐ Check Here if additional notes on back

Description of Pain: ☐ Burning ☑ Stabbing ☐ Dull/Achy ☐ Pressure-like ☐ Crushing ☐ Other: ____

Duration of Pain: 9 15 to 20 mins Does anything relieve the pain? NO

Onset of Pain: ☑ New onset ☐ Sudden ☑ Gradual ☐ Chronic Pain Scale: (1-10) 8 History of injury? ☐ YES ☑ NO

Radiation: ☐ No radiation ☑ Radiation to: L Arm & Stomach

Aggravating Factors: ☐ Exertion ☐ Stress ☐ Food intake ☑ Movement ☐ Coughing ☑ Other: Deep Breath

Associated Symptoms: ☐ Nausea/Vomiting ☐ Diaphoresis ☐ Dyspnea ☐ Syncope ☐ Cough ☐ Sputum production ☐ Hemoptysis ☐ Fever ☐ Chills

Cardiac Risk Factors: ☐ Family history ☐ Smoke: ___ppd/___ years ☐ Hypertension ☐ Diabetes ☐ Hyperlipidemia ☐ CAD

History of: ☐ Peptic ulcer ☐ Illicit drug use ☐ Cardiac disease ☑ Nitroglycerin use

Objective: Vital Signs: (As Indicated) T: 98 P: 68 RR: 18 B/P: 128 / 80

Pulse Ox %: 98 % ☑ Room Air ☐ O2 LPM: ____

General Appearance: ☑ No acute distress ☑ Alert ☑ Oriented x 3 ☐ Anxious ☐ Acute distress

Color: ☑ Normal ☐ Pale ☐ Flushed ☐ Cyanotic ☐ Jaundiced

Skin: ☑ Warm ☑ Dry ☐ Cool ☐ Moist/Clammy

EKG ordered? ☑ YES ☐ NO

EKG interpretation / computer read or available for physician? ☑ YES ☐ NO

Lung sounds:

Right		Left
☑	Clear	☑
☐	Diminished	☐
☐	Crackles	☐
☐	Rhonchi	☐
☐	Wheezing	☐

☑ Additional Examination: Pt talking & laughing c officer p AM Meds were given. States "I feel much better."
(Continue on back if necessary)

☐ Check Here if continued on back

Assessment: (Referral Status) Preliminary Determination(s): Alt in Comfort / RT (L) Side Chest + Stomach

☐ Referral NOT Required

☐ Referral Required due to the following: (Check all that apply)

☐ Acute distress ☐ Abnormal vital signs ☐ Recurrent Complaint (More than 2 visits for same complaint)

☐ Cardiac history ☑ Suspicious cardiac symptomology ☐ Cardiac Risk Factor present

☐ History of recent illicit drug use ☐ Other: ____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Noted 2/6/06

Plan: Check All That Apply: *Acute distress* – arrange for immediate emergency transport

☐ Administer oxygen if in acute distress ☑ ASA 325 mg po already prescribed AM meds

☑ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☑ Instructions to return if condition worsens.

☑ Other: Already has MD appt for Am (Describe)

OTC Medications given ☑ NO ☑ YES (If Yes List): prescribed AM meds given, Maalox 30 cc Na

Referral: ☐ NO ☑ YES (If Yes, Whom/Where): Dr Darbouze Date for referral: 2 / 6 / 2006 (MM DD YYYY)

Referral Type: ☑ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): ____ Time ____

x Cammon Lonnie Name: D. Shehane

PHS

Nursing Evaluation Tool: Chest Pain

Facility: Easterling

Patient Name: CAmmon (Last) Lonnie (First) MI

Inmate Number: 238498

Date of Birth: [redacted]

Date of Report: 1 / 19 / 2006 (MM/DD/YYYY)

Time Seen: 4P AM (PM) Circle One

Subjective: Chief Complaint(s): c/o LT. Arm -and- Chest LT-side And down to Abd

Onset: Today

Activity prior to onset:

History: States Feel I had stroke before Feels like that bottom Abd. hurt yesterday

(Continue on back if necessary)

☐ Check Here if additional notes on back

Description of Pain: ☐ Burning ☒ Stabbing ☐ Dull/Achy ☒ Pressure-like ☐ Crushing ☐ Other:

Duration of Pain:

Does anything relieve the pain? Tooth paste smoothie

Onset of Pain: ☐ New onset ☐ Sudden ☐ Gradual ☐ Chronic Pain Scale: (1-10) Bad ks History of injury? ☐ YES ☐ NO

Radiation: ☐ No radiation ☒ Radiation to: LT Arm

Aggravating Factors: ☐ Exertion ☐ Stress ☐ Food intake ☐ Movement ☐ Coughing ☐ Other:

Associated Symptoms: ☐ Nausea/Vomiting ☐ Diaphoresis ☐ Dyspnea ☐ Syncope ☐ Cough ☐ Sputum production ☐ Hemoptysis ☐ Fever ☐ Chills

Cardiac Risk Factors: ☐ Family history ☐ Smoke: ___ppd/___ years ☐ Hypertension ☐ Diabetes ☐ Hyperlipidemia ☐ CAD

History of: ☐ Peptic ulcer ☐ Illicit drug use ☐ Cardiac disease ☐ Nitroglycerin use

Objective: Vital Signs: (As Indicated) T: 97.6 P: 67 RR: 16 B/P: 110 / 78

Pulse Ox %: 99 % ☐ Room Air ☐ O2 LPM:

General Appearance: ☐ No acute distress ☒ Alert ☒ Oriented x 3 ☐ Anxious ☐ Acute distress

Color: ☒ Normal ☐ Pale ☐ Flushed ☐ Cyanotic ☐ Jaundiced

Skin: ☒ Warm ☒ Dry ☐ Cool ☐ Moist/Clammy

EKG ordered? ☒ YES ☐ NO

EKG interpretation / computer read or available for physician? ☒ YES ☐ NO

Lung sounds:

Right		Left
☐	Clear	☒
☐	Diminished	☐
☐	Crackles	☐
☐	Rhonchi	☐
☐	Wheezing	☐

☐ Additional Examination: DR Darbouze called 5:50 PM stated he could go PT - stated it is doing good Nitroglycerin 4:30 PM Mylanta 30cc X2 10 4:50 PM orders received

(Continue on back if necessary)

☐ Check Here if continued on back

Assessment: (Referral Status)

Preliminary Determination(s):

Noted 1/27/06

☐ Referral NOT Required

☐ Referral Required due to the following: (Check all that apply)

☐ Acute distress ☐ Abnormal vital signs ☐ Recurrent Complaint (More than 2 visits for same complaint)

☐ Cardiac history ☐ Suspicious cardiac symptomology ☐ Cardiac Risk Factor present

☐ History of recent illicit drug use ☐ Other:

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply: *Acute distress* – **arrange for immediate emergency transport**

☐ Administer oxygen if in acute distress ☐ ASA ________mg po

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Instructions to return if condition worsens

☐ Other: Nitroglycerin 0.4 mg PO SL - Mylanta 1 T Gm Hold rec if helps / DR Darbouze (Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): DR Darbouze Date for referral: 1 / 19 / 2006

Referral Type: ☐ Routine ☒ Urgent ☐ Emergent (if emergent who was contacted?): DR Darbouze Time 4:25

x [signature] Nurses Signature Name: D. [signature] Printed

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 1/19/06
ID # 238498 Date of Birth: [redacted] Location: 7B/60
Nature of problem or request: Back Pain & Arthritis

Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: ____/____/____
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: **P:** **R:** **BP:** **WT:**

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLE-1002 (1/4)

PHS

Nursing Evaluation Tool: General Sick Call

Facility: ECF
Patient Name: Common (Last) Lonnie (First)
Inmate Number: 238498
Date of Birth: [redacted] (MM DD YYYY)
Date of Report: 1 / 16 / 2006 (MM DD YYYY)
Time Seen: 900 AM / (PM) Circle One

Subjective: Chief Complaint(s): "profile for lay-in and extra blanket"

Onset:

Brief History: B/m to HCU. A+Ox3. Skin warm et dry to touch. Resp even et unlabored. Requests profiles to have extra blanket and lay-in profile.

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 74 RR: 20 B/P: 120 / 74

Examination Findings: Has hx of DJD, CVA, bladder incontinence MAU noted.

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s): alt in health maintance

☐ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☒ Other: Needs profiled - nurse cannot give.

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given

Plan: Check All That Apply:

☒ Instructions to return if condition worsens

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe)

OTC Medications given ☒ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): TScott Date for referral: 1/29/06 (MM DD YYYY)

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

x TScott
Nurses Signature

Name: T. Scott lpn
Printed

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Common Date of Request: _____
ID # 238498 Date of Birth: [redacted] Location: 7-B-60
Nature of problem or request: To ask the doctor for a lay in profile and a extra blanket. I stay cold and sick

Lonnie Common
Signature

DO NOT WRITE BELOW THIS LINE

Date: ____/____/____
Time: _____ AM PM
Allergies: _____

RECEIVED
Date: JAN 14 2006
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: **P:** **R:** **BP:** **WT:**

(A)ssessment: See Net

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 12/22/05
ID # 238498 Date of Birth: [redacted] ation: 7B/60
Nature of problem or request: Need to see Eye Cataracts.

Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date: 12/23/05
Time:
Receiving Nurse Intials AMC

(S)ubjective:

(O)bjective (V/S): T: **P:** **R:** **BP:** **WT:**

(A)ssessment:

see net dated 12-26-05 CN

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS

Nursing Evaluation Tool: General Sick Call

Facility: ECF
Patient Name: Cammon, Lonnie (Last, First, MI)
Inmate Number: 238498
Date of Birth: [redacted] (MM DD)
Date of Report: 12/21/05 (MM DD YYYY)
Time Seen: 8:05 AM / PM (Circle One)

Subjective Chief Complaint(s): "I have cataracts"

Onset: Chronic

Brief History: (Continue on back if necessary) States "I can't see out of my ~~O~~ error w eye left eye because the cataract grew over it." States was on eye drops at Kilby but "it ~~tears~~ emora ran out." States still has artificial tear drops "but it's getting low."

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98° P: 72 RR: 16 B/P: 98 / 64

Examination Findings: (Continue on back if necessary) B/M ambulates to HCU c even, steady gait. A+O x3 Resp even + unlabored. Skin warm + dry. vision screen c glasses done: OD - 20/50 OS - unable to see chart per pt ~~O~~ distress noted

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

☐ Referral NOT REQUIRED

☒ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☒ Other: unresolvable by nurse

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given

noted 12/26

Plan: Check All That Apply:

☐ ~~Instructions~~ to return if condition worsens

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up ☒ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes Whom/Where): MD Date for referral: 12/29/05 (MM DD YYYY)

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

x CWambles, RN
Nurses Signature

Name: CWambles, RN
Printed

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 11/30/05
ID # 238498 Date of Birth: [redacted] Location: 7B/60
Nature of problem or request: Back Hurting Very much Need to see Doctor

Signature

DO NOT WRITE BELOW THIS LINE

Date: ____/____/____
Time: _____ AM PM
Allergies: _____

RECEIVED
Date: DEC 2 2005
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: **P:** **R:** **BP:** **WT:**

(A)ssessment: Waiver

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Common Date of Request: 11/22/05
ID # 238498 Date of Birth: [redacted] Location: 7B60
Nature of problem or request: Need to see Dr. Barbour for my back + my rt side

Signature

DO NOT WRITE BELOW THIS LINE

Date: ____/____/____
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: _____ **P:** _____ **R:** _____ **BP:** _____ **WT:** _____

(A)ssessment: See Ret

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
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PHS

Nursing Evaluation Tool: Back Pain

Facility: ECF

Patient Name: Cammon Lonnie (Last First MI)

Inmate Number: 238498

Date of Report: 11 / 23 / 05 (MM DD YYYY)

Date of Birth: [redacted] (MM DD YYYY)

Time Seen: 8:45 AM / (PM) Circle One

Subjective Chief Complaint(s): back pain

Onset: a long time

☐ New onset ☒ Chronic condition exacerbation

Pain Scale: (1-10) 8 Type: ☐ Sharp ☐ Dull ☐ Intermittent ☒ Constant Numbness: ☐ No ☐ Yes

Location of Pain: lower (Neck / mid-back / low back) Radiation of pain: ☐ No ☒ Yes to: Rt side of Body

History: "I Can't stand to walk b/c my (R) Lg Side out b/c my lower back hurts" (Continue on back if necessary)

☐ Check Here if additional notes on back

Associated symptoms: Pain on urination? ☒ No ☐ Yes Nausea ☒ No ☐ Yes Vomiting ☐ No ☐ Yes (x)

Increased urination? ☒ No ☐ Yes Pain with cough/breathing? ☒ No ☐ Yes

Objective: Vital Signs: (If Indicated) T: 98 P: 64 RR: 18 B/P: 138 / 70

Back Exam: ☐ Tender to touch ☐ Contusion ☒ Muscle spasms ☐ Impaired range of motion

Additional Findings: ☐ Numbness ☐ Tingling ☒ Abnormal gait ☐ Weakness of extremities ☐ Foot drop ☐ Other:

Elaborate positive findings:

☐ Check Here if additional notes on back

Lower extremities: ☒ Normal ☐ Abnormal (Describe):

Pedal pulses: ☒ Present ☐ Absent

☒ Additional Examination: denies any injuries (Continue on back if necessary)

☐ Check Here if continued on back

Assessment: (Referral Status)

☐ Referral NOT Required

Preliminary Determination(s):

☒ Referral Required due to the following: (Check all that apply)

☐ Loss of sensation ☐ Presence of RBCs from dipstick ☒ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Prior malignancy ☐ Presence of WBCs from dipstick

☐ Other:

Plan:

Check All That Apply: ☐ Work and recreation restrictions x 72 hours

☒ Education on avoiding back pain ☐ Education about stretching and back exercises ☒ Instructions to return if condition worsens

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe)

☐ Cold Compress (Acute injury) ☐ Warm Compress

☐ OTC Medications given ☐ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr Dunbar Date for referral: / / (MM DD YYYY)

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

x [signature] Nurses Signature Name: C Garcia (Dy) Printed

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie CAMMON Date of Request: 11/9/05
ID # 238496 Date of Birth: [redacted] Location: 7B60
Nature of problem or request: I am having Bad Back Pain it hurts to sit up or lay Down

Lonnie Common
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

See MD

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS

Nursing Evaluation Tool: General Sick Call

Facility: ECF

Patient Name: CAmmon (Last) Lonnie (First) (MI)

Inmate Number: 238498

Date of Birth: [redacted]

Date of Report: 10 / 10 / 2005 (MM DD YYYY)

Time Seen: 930 AM / (PM) Circle One

Subjective: Chief Complaint(s): C/o Back pain

Onset:

Brief History: He has Already Seen Dr 10-25 - Pain Medication order TID PRN
(Continue on back if necessary)
States he comes morning and Afternoon but he does not come As he should
States he is to old to walk to get his medication
Still wants to see Dr.

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97 P: 70 RR: 16 B/P: 100 / 70

Examination Findings:
(Continue on back if necessary)

☐ Check Here if additional notes on back

Assessment: *(Referral Status)* Preliminary Determination(s):

☐ Referral NOT REQUIRED

☐ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☒ Other: Wants to See Dr.

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☒ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe)

OTC Medications given ☒ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes Whom/Where): Dr. Darbouze Date for referral: 11 / 14 / 2005 (MM DD YYYY)

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

x [signature] Nurses Signature Name: D. Barrow LPN / [signature] Printed

PHS

Nursing Evaluation Tool: Dermatitis (Rashes)

Facility: Easterling

Patient Name: Cannon (Last) Lonnie (First) MI

Inmate Number: 238498

Date of Birth: [redacted] (MM DD YYYY)

Date of Report: 10 / 23 / 05 (MM DD YYYY)

Time Seen: 0907 AM / (PM) Circle One

Subjective: Chief Complaint: ☑ Itching ☑ Burning ☐ Redness ☑ Swelling ☐ Weeping ☐ Blisters ☐ Lice/Scabies/Nits

☐ Other:

Onset: "about September"

Location: upper legs bilateally lower arms bilateally lower back

History: "I've been itching since I got here"

(Continue on back if necessary)

☐ Check Here if additional notes on back

Associated Symptoms: ☐ None ☐ Fever ☐ Upper Respiratory Symptoms ☐ Tongue Swelling/Throat Closing ☐ Facial/Neck Swelling

☐ Difficulty breathing ☑ Other: (L) lower arm swollen c 1+ pitting edema

Recent environmental contacts (allergens/Irritants): denies

History of new medication: denies

Objective: Vital Signs: (If Indicated) T: 98.8 P: 78 RR: 18 B/P: 143 / 82

Exam: Lesion(s): ☑ NO ☐ YES Description:

Redness/Swelling/Streaking: ☐ NO ☑ YES (If Yes, Describe):

☐ Additional Examination: scratch marks visible lower back and lower arms bilateally

Continue on back if necessary)

RT itching

☐ Check Here if continued on back

Assessment: (Referral Status)

Preliminary Determination(s):

☐ Referral NOT Required

☑ Referral Required referral due to the following: (Check all that apply)

☐ Respiratory distress ☐ Tongue or facial swelling ☐ Hives ☐ Wheezing

☐ New medication ☐ Signs of infection ☐ Recurrent Complaint (More than 2 visits)

☑ Other: MD evaluate and treat

(Describe)

Plan: Check All That Apply:

☐ Meds given per approved OTC med list: ☑ Hydrocortisone 1% cream to affected area BID x 7da

☐

☑ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☑ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Education signs and symptoms of severe allergic reaction: (Difficulty breathing, throat or facial swelling) Pt instructed to seek immediate seek immediate medical attention if these should occur

Other OTC Medications given ☑ NO ☐ YES (If Yes List):

Referral: ☐ NO ☑ YES (If Yes, Whom/Where): Dr Darbeze Date for referral: 10 / 25 / 05 (MM DD YYYY)

Referral Type: ☑ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

x Lisa Hamilton LPN

Nurses Signature

Name: LISA JO HAMILTON LPN

Printed

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cameron Date of Request: 10/20/05
ID # 238498 Date of Birth: [redacted] ation: 7B/69
Nature of problem or request: I am scratching my self to death. Very itchy. Need to see the Doctor ASAP!!

Signature

DO NOT WRITE BELOW THIS LINE

Date: ____/____/____
Time: _____ AM PM
Allergies: _____

RECEIVED
Date: OCT 21 2005
Time:
Receiving Nurse Intials AMC

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment: Please See Net dated 10/23/05

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: LONNIE CAMMON Date of Request: _____
ID # 238498 Date of Birth: [redacted] Location: 7B-60
Nature of problem or request: I AM BREAKING OUT ALL OVER MY BODY WITH A RASH, I AM ITCHING TO DEATH, I HAVE SCRATCHED THE BLOOD OUT OF MY LEGS. PLEASE SEE ME AS SOON AS POSSIBLE. I SUSPECT SCABBIES!
Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time: 9/17
Receiving Nurse Intials MWP

(S)ubjective:

(O)bjective (V/S): T: _____ **P:** _____ **R:** _____ **BP:** _____ **WT:** _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS
PRISON
HEALTH
SERVICES
INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Lonnie Cammon

Date of Birth: [redacted] Social Security No.: [redacted]

Date: 9-18-05 Time: 8:49 A.M. P.M.

This is to certify that I, Lonnie Cammon (Print Inmate's Name), currently in custody at the Easterling (Print Facility's Name), am refusing to accept the following treatment/recommendations: Breaking out sick (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Lonnie Cammon
(Signature of Inmate)**

(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member

60115 (5/85)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: LONNIE CAMMON Date of Request: 9/5/05
ID # 238498 Date of Birth: [redacted] Location: 7B-60
Nature of problem or request: I'm Requesting to See the Doctor Concerning me Getting A No Long Standing profile for m eating my food I Can't Eat fast and Swollen my food and I Can't walk that fast if you Can Help in this matter I Really would Appricate It. LONNIE CAMMON
Signature

DO NOT WRITE BELOW THIS LINE

Date: ____/____/____
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment: Waiver Signed

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

Date/Time	Inmate's Name: Cumman, Lonnie D.O.B.: [redacted]
8/22/05	Inmate received to Easterling. Access to Health Care, S/C, et kitchen clearance explained to inmate.
8/23/05	Chart screened by Mental Health. — R Flowers, L

PHS PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record

Institution: Easterling

Date: 8/22/05 Time: 10:04 AM/PM

RECEIVED FROM:
Institution/Work Release Center/Free-World Hospital

RECEIVING MEDICAL STATUS
- [x] Population
- [ ] Infirmary
- [ ] Isolation

RELEASED: Inmate/Health Record

Institution: Kilby

Date: 8/21/05 Time: ______ AM/PM

RELEASE FROM:
- [ ] Infirmary
- [ ] Segregation
- [x] Population
- [ ] Mental Health
- [ ] Other

RELEASE TO:
- [x] DOC
- [ ] Infirmary
- [ ] Mental Health
- [ ] Easterling

Institution/Work Release Center/Free-World Hospital

ALLERGIES: NKDA

PHYSICAL EXAMINATION

Date of last exam: 3/17/05

Chest X-Ray Date: / Result:

PPD Reading: 3/19/05 0

Classification: I

Limitations: none

LAB RESULTS - - LAST REPORT

	Date	Normal	Abnormal
CBC	3/17/05	✓	
Urinalysis	3/17/05	✓	

	YES	NO
Wears Glasses/Contacts	X	
Dental Prosthesis	X	
Hearing Aide		X
Other Prosthesis		X

Wallemore, LPN — Recieving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

Glucoma

CURRENT MEDICATION - - DOSAGE AND FREQUENCY

Artificial tears
Cosopt opthal sts
Dhropansy [illegible] BID

MEDICATIONS	[x] Sent w / inmate	[ ] Not sent w / inmate
X-RAY FILM	[ ] Sent w / inmate	[x] Not sent w / inmate
HEALTH RECORD	[x] Sent w / inmate	[ ] Not sent w / inmate

Released to: ADOC

Date: 8/21/05 Time: ______ AM/PM

MEDICATIONS	[x] Received	[ ] Not Received
X-RAY FILM	[ ] Received	[x] Not Received
HEALTH RECORD	[x] Received	[ ] Not Received
CHART REVIEWED	[x] YES	[ ] NO

Received by: Wallemore, lpn
Signature of Receiving Nurse

Date: 8/22/05 Time: 10:04 AM/PM

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: N/A LAST CLINIC:

FOLLOW-UP CARE NEEDED
- [x] Medical
- [x] Dental
- [ ] Mental Health

Date | Time | With Whom - - Location (Sending Nurse) | Date/Appt Made w/Whom (Rec. Nurs

PRN

NURSING ASSESSMENT (SENDING NURSE) (Noted from health record documentation)

		Yes	No
HISTORY	Drug Use		✓
	Mental Illness		✓
	Suicide Attempt		✓
	Chronic Care		✓
STATUS	Special Diet		✓
	Appearance		

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE) (Noted from inmate assessment)

		Yes	No
SKIN	Open Sores		X
	Lice		X
	Edema		X
	Warm & Dry	X	X
	Cool & Moist		X
CONDITION	Alert	X	
	Oriented	X	
	Uncooperative		X
	Depressed		X

INTAKE

Sick Call Procedures Explained: W

Height: 5'9

Weight: 128

Blood Pressure: 152/72

Temperature: 97.1

Pulse Resp: 52

Other

[signature] 8/21/05 Wallemore, lpn 8/22/

Signature of Nurse Completing Assessment (Sending Nurse) Date Signature of Intake Screening Nurse (Receiving Nurse) Date

INMATE NAME (LAST FIRST MIDDLE)	DOC#	DOB	Race/Sex	FAC
CAMMON LONNIE	238498	[redacted]	B/M	KCF

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Cammon, Lonnie 238498

D.O.B. [redacted]

ALLERGIES: NKDA NKDA

Use Last Date 8/1/05

DIAGNOSIS (If Chg'd)

KOP → ARTIFICIAL TEARS x180 d PRN

— DO NOT INTERRUPT COSOPT TX

— NO ART. TEARS FOR 30 MIN ā COSOPT

[signature]

noted 8-5-05

☐ GENERIC SUBSTITUTION IS NOT PERMITTED [signature]

NAME: Cammon, Lonnie 238498

D.O.B. / / 7/15/05 730A noted [signature]

ALLERGIES:

Use Fourth Date 7/15/05

DIAGNOSIS (If Chg'd)

Benadryl 50mg PO BID PRN x 10d

VO B Adams CRNP / [signature], LPN

☐ GENERIC SUBSTITUTION IS NOT PERMITTED B Adams CRNP

NAME: Cammon, Lonnie 238498 7/11/05 900A noted [signature]

D.O.B. /

ALLERGIES: NKDA

Use Third Date 7/11/05

DIAGNOSIS (If Chg'd)

① Eye List (next available)

② Ditropan 5mg p.o. BID x 90d

☐ GENERIC SUBSTITUTION IS NOT PERMITTED B Adams CRNP

NAME: CAMMON LONNIE 238498

D.O.B. [redacted]

ALLERGIES: NKDA

Use Second Date 6/26/05

DIAGNOSIS (If Chg'd)

CONTINUE COSOPT i gt OD/OS bid

F/U @ 6 mos

[signature] RN 6/24/05 @ 1425

☐ GENERIC SUBSTITUTION IS NOT PERMITTED [signature]

NAME: Cammon, Lonnie 238498 6/16/05 11Am noted [signature]

D.O.B. / /

ALLERGIES: NKDA

Use First Date 6/16/05

DIAGNOSIS

① Elimite (or equiv.) TOP to entire body (below neck) tonight ā warm shower; leave on x 8 hours & shower off in A.M.

② Benadryl 50mg p.o. BID x 10d PRN

③ New clothes, linens, etc.

☐ GENERIC SUBSTITUTION IS NOT PERMITTED B Adams CRNP

MEDICAL RECORDS COPY

60110 (4/03)

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: CAMMON, LONNIE 238498 D.O.B. / / ALLERGIES: Use Last Date 6, 3, 5	DIAGNOSIS (If Chg'd) ① CONTINUE COSOPT bid ou/os (q12h) KOP ② AM KILBY IN JUNE ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: CAMMON, LONNIE 238498 D.O.B. / / ALLERGIES: Use Fourth Date 5, 13, 5	DIAGNOSIS (If Chg'd) ① CONTINUE COSOPT gtt ou/os b.i.d x 180d ② AM KILBY CLINIC (DFE/IOP) @ 2 wks ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Cammon, Lonnie 238498 4/25/05 1005 A noted [signature] D.O.B. / / ALLERGIES: NKDA Use Third Date 4, 25, 05	DIAGNOSIS (If Chg'd) ① ZANTAC 150 mg p.o. BID x 30d ② Antacids ii p.o. BID x 90d PRN ③ Tylenol 650 mg p.o. BID x 90d PRN ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Cammon, Lonnie 238498 D.O.B. [redacted] ALLERGIES: NKDA Use Second Date 4/8/05	DIAGNOSIS (If Chg'd) continue AFC KOP x 4 weeks noted: [signature] @ 1125 ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: CAMMON, LONNIE 238498 4/6/05 950A noted [signature] D.O.B. / / ALLERGIES: NKDA Use First Date 4/6/05	DIAGNOSIS Medical Hold until AFTER 4-20-05 Bicillin 2.4 mu IM qwk x 3 Entex PSE i PO BID x 7d VO M. Webb CRNP / [signature] ☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

60110 (4/03)

PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Cammon, Lonnie 238498
D.O.B. [redacted]
ALLERGIES: NKDA
Use Last Date 04/04/05

noted 4/4/05 1420 Linda Bell RN

DIAGNOSIS (If Chg'd)
DDC Diamox
2) Cosopt 2x/day both eyes
3) See Dr. Brad Ford next month for cataract follow-up
V.O. Dr. Swanner / Linda Bell RN
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: CAMMON, LONNIE 238498
D.O.B. / /
ALLERGIES:
Use Fourth Date 4/1/05

noted 4/1/05 1500 Linda Bell RN

DIAGNOSIS (If Chg'd)
NEEDS IMMEDIATE REFERRAL TO UAB GLAUCOMA SPECIALIST
1) Diamox 250 → po bid #14 Call to Walgreen Y. Bell RN 1235
2) Timoptic 1/2% os bid Call to Walgreen Y. Bell RN 12
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cammon, Lonnie 238498
D.O.B. [redacted]
ALLERGIES: NKDA
Use Third Date 03/28/05

3/28/05 UA noted [illegible]

DIAGNOSIS (If Chg'd)
UA
AFB BID X10D RDP
Nitropan 5mg PO BID X90D
OPC 1 mo
☐ GENERIC SUBSTITUTION IS NOT PERMITTED M Webb CMA

NAME: Cammon, Lonnie 238498
D.O.B. [redacted]
ALLERGIES: NKDA
Use Second Date 03/17/05 10:35 AM

3-17-05

DIAGNOSIS (If Chg'd)
eye list: glaucoma OS
Naprosyn 250 mg PO BID PRN 30d
☐ GENERIC SUBSTITUTION IS NOT PERMITTED M Webb CMA

NAME: Cammon, Lonnie 238498
D.O.B. [redacted]
ALLERGIES: NKDA
Use First Date 3/17/05 9:25 AM

3-17-05

DIAGNOSIS
EKG, CXR
CMP, CHO, PSA
Td 0.5cc IMX1
Bottom Bunk X 180d
Nom Webb CRNP / [illegible] RN
☐ GENERIC SUBSTITUTION IS NOT PERMITTED

110 (4/03)

MEDICAL RECORDS COPY

PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Cannon, Lonnie D.O.B.: / /
6/16/05 1050	Pt. clo rash to entire body. Integ- macular papular rash ~ burrows noted to (B) arms, Abd., back, chest, groin c/w scabies A/P: 1) Scabies - Elimite / Scabies protocal - Benadryl - Flu ~ 1 mo E: TX plan [signature] LRN
7/11/05	Pt. clo "eyes burning" ~ putting in gtts. Requests ditropan refill. VSS; Alox 3; Asymptomatic @ present Hx of cataracts to (B) eyes Seen by opth. on 6/24/05 HEENT - glasses Pupils Reactive to light (R) < (L) Ø Δ since initial PE A/P: 1) Overactive bladder Reorder ditro pan 2) Hx Cataracts / Glaucoma - Cont. gtts - eye list

PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Cammon, Lonnie D.O.B. [redacted]
03/28/05 1025	(S) 77 yo BM PMH +CVA 10-12 yrs ago. #1 c/o urinary urgency + frequency with "leaking all over clothes" #2 c/o rash d/t soap - insists 'state soap' is the problem. Took ditropan XL on street for "bladder weakness"
	(O) Groin appears to have fungal rash - worse on scrotum & inner thighs
	(A) incontinence - r/o UTI
	tined
	(P) UA (intake results not on chart)
	AFB MWebb CMA
	ditropan 5mg PO BID, OPC 1 mo
4/25/05 1000	Pt. c/o indigestion / heart burn p meals & chronic arthritis pain "all over".
	PE. - unremarkable
	A/P: 1) chronic arthritis
	- Tylenol / moist heat PRN
	2) GERD
	Zantac / antacids
	Flu 3 mos
	Barbara LRN

60111 (5/85)

Complete Both Sides Before Using Another Sheet

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: CAMMON LONNIE Date of Request: 7-27-05
ID # 238498 Date of Birth: [redacted] Location: W-22
Nature of problem or request: My Med RUN out I Need to see the DOCTOR For ReFill

Jonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: 7/28/05
Time: 9:30 (AM) PM
Allergies: NKA

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective: My Medication Needed D/t the itching arms, back, legs

(O)bjective (V/S): T: 97.7 P: 64 R: 20 BP: 128/60 WT: 130
Alert oriented x 3 skin warm et dry raised area on body part.

(A)ssessment: Altered health state r/t dry Medication renewed

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

Pt. left before exam
Called x 6
7/28/05
CR

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Flu Rx

GLF-1002 (1/4)

PHS
PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: CAMMON LONNIE Date of Request: 7-14-05
ID # 238498 Date of Birth: [redacted] Location: ______
Nature of problem or request: Breaking out CANT hold water

Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: 7/15/05
Time: 735 (AM) PM
Allergies: NKDA

RECEIVED
Date: 7-15-05
Time: 735A
Receiving Nurse Intials n

(S)ubjective: ① Hurting in stomach - I can't hold my H2O.
① Rash - itching really bad.

(O)bjective **(V/S):** **T:** 97.9 **P:** 60 **R:** 18 **BP:** 123/66 **WT:** 137
A+O x3. Resp. reg c ease. VS WNL NAD
7740 Bm taking Ditropan started 7/11/05

(A)ssessment: Alt. in comfort R/T above statement

(P)lan: ~~SC AP~~ Benadryl 50mg PO BID PRN x 10d
Pill call for Ditropan

Refer to: MD/PA Mental Health Dental Daily Treatment (Return to Clinic PRN)
CIRCLE ONE
Check One: ROUTINE (✓) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

7/14/05
[illegible]

Graves, LPN
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 7-8-05
ID # 238498 Date of Birth: [redacted] Location: West 22
Nature of problem or request: Eyes are hurting all night and all day

Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: 7/11/05
Time: 800 (AM) PM
Allergies: NKDA

RECEIVED
Date: 7-11-05
Time: 800
Receiving Nurse Intials JJ

(S)ubjective: Burning eyes x 1 wk. Night + Day.

(O)bjective (V/S): T: 100° P: 70 R: 20 BP: 133/60 WT: 132
Hx of Cataracts to Both eyes 7740 Bm.
20/40 OU

(A)ssessment: Pt in comfort R/T above statement

(P)lan: See MP

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE (✓ EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

Graves, rn 7/11/05
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLE-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 6/16/05

To: DOC

From: OPC

Inmate Name: CANNON, LONNIE **ID#:** 238498

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

KOP Elimite

Apply AFTER WARM Shower leave it on 8°. Shower off in A.M.

DOC Please ISSUE NEW clothes, LINEN, etc AFTER Receiving elimite

Date: 6/16/05 **MD Signature:** VO B. Adams CRNP/NP **Time:** _____

60418

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie CAMMON Date of Request: June 15, 2005
ID # 236498 Date of Birth: [redacted] Location: W-22
Nature of problem or request: I have a RASH problem in my arm and BACK area. Its getting worse and I really need alot of cream. Please help me with this MATTER.
Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: 6/16/05
Time: 730 (AM) PM
Allergies: NKA

RECEIVED
Date: 6-16-05
Time: 730
Receiving Nurse Intials JJ

(S)ubjective: I'm breaking out in a rash Both arms, Between legs armpits + Back itches really bad.

(O)bjective (V/S): T: 97.5 P: 64 R: 20 BP: 133/63 WT: 135
Red Rash like area noted to Lt arm
77 40 BM C Hx of stroke, arthritis.

(A)ssessment: Alert in comfort Rt above

(P)lan: See NP

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE (✓) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

6/16/05
Graves, LPN
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Cammon Lonnie .

Date of Birth: [redacted] Social Security No.:

Date: 5/23/05 Time: 6:15 A.M. P.M.

This is to certify that I, Cammon Lonnie (Print Inmate's Name), currently in custody at the Kilby (Print Facility's Name), am refusing to accept the following treatment/recommendations: IO Tired To sit in one Place. (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Lonnie Cammon
(Signature of Inmate)**

Lonnie Grimes, LPN
(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 4/23/05
ID # 238498 Date of Birth: [redacted] ation: W-22
Nature of problem or request: Problems with lightheadedness and am feeling weak. Serious headaches and bodyaches. Arthritic back and pain in right side. After meals I'm having problems keeping food down.

Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: 4/25/05
Time: 650 (AM) PM
Allergies: NKDA

RECEIVED
Date: 4-25-05
Time: 650A
Receiving Nurse Intials JT

(S)ubjective: Everything I eat hurt my stomach lightheaded & feeling weak x 2 wks.

(O)bjective (V/S): T: 97.8 P: 96 R: 18 BP: 142/10 WT: 150
7740 BM

(A)ssessment: Alert in comfort R/T above statement

(P)lan: See NP

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE (✓) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

4/25/05

Graves, LPN
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Cammon, Lonnie 238498

Date of Birth: [redacted] Social Security No.: _____

Date: 4-11-05 Time: 710 A.M. P.M.

This is to certify that I, Lonnie Cammon (Print Inmate's Name), currently in custody at the KILBY (Print Facility's Name), am refusing to accept the following treatment/recommendations: sick call because my cDdd is better (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare

X Lonnie Cammon (Signature of Inmate)**

Yolaine Brown (Signature of Medical Person)

_____ (Witness)

_____ (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Caldwell, Sean 239499

Date of Birth: [redacted] Social Security No: _____

Date: 4-11-05 Time: 815 AM / PM

This is to certify that I, Sean Caldwell (Print Inmate's Name), currently in custody at the KILBY (Print Facility's Name), am refusing to accept the following treatment/recommendations: Sickcall because I'm tired waiting (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

X Sean Caldwell (Signature of Inmate)**

Lorraine Brown (Signature of Medical Person)

_____ (Witness)

_____ (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PHS
PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 4/18/05 TIME AM PM
ORIGINATING FACILITY KCF ☐ SIR ☐ PDL ☐ ESCAPEE ☐
☐ SICK CALL ☐ EMERGENCY ☐ OUTPATIENT

ALLERGIES

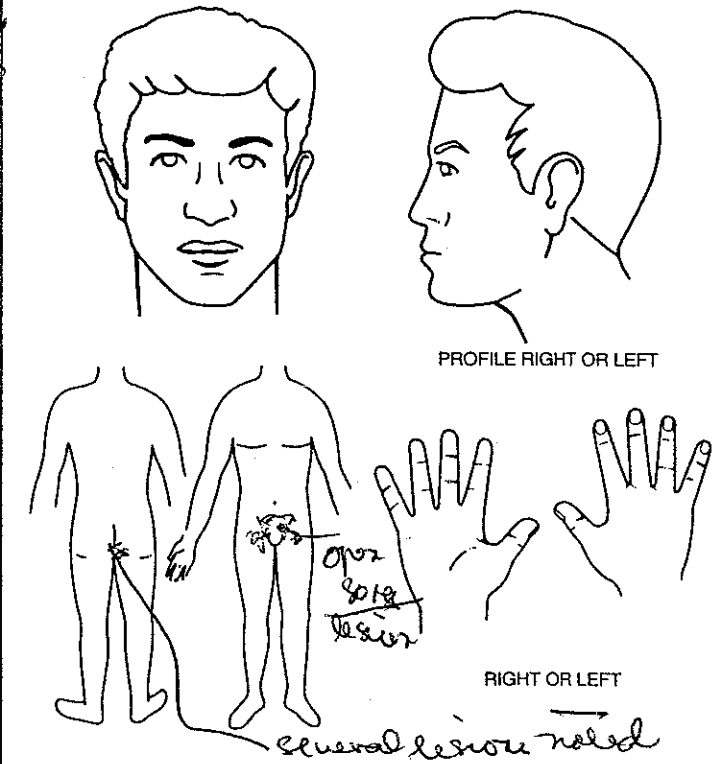
CONDITION ON ADMISSION ☐ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 97.2 ORAL RECTAL RESP 18 PULSE 80 B/P 130/76 RECHECK IF SYSTOLIC <100> 50 ___/___

NATURE OF INJURY OR ILLNESS

S - "I'm raw down there and I could hardly walk."
O - alert x 3. Ambulatory open lesions noted around scrotal area and rectal area. States he was given a shot last Wednesday.

ABRASION /// CONTUSION # BURN XX XX FRACTURE Z Z LACERATION / ___ SUTURES



PHYSICAL EXAMINATION

A - Altered comfort level r/t lesions/open sores around scrotal area

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY
P - Refer to CRNP/MD		
ordered to continue ATC		
KOP x 4-6 weeks		

DIAGNOSIS

INSTRUCTIONS TO PATIENT

DISCHARGE DATE 4/18/05 TIME AM PM
RELEASE / TRANSFERRED TO ☐ DOC ☐ AMBULANCE ☐
CONDITION ON DISCHARGE ☐ SATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL

NURSE'S SIGNATURE J. Dorquier DATE 4/18/05
PHYSICIAN'S SIGNATURE @ 4/11/05 DATE
CONSULTATION

INMATE NAME (LAST, FIRST MIDDLE)	DOC#	DOB	R/S	FAC
CAMMON, LONNIE	238498	[redacted]	B/M	KCF

PHS PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: LONNIE CAMMON [redacted] Date of Request: 4-5-05

ID # 238498 Date of [redacted] Location: W-22

Nature of problem or request: ~~I have COLD IN MY BODY~~

I have a extremely bad cold.

Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: 4/6/05
Time: 930 AM (circled) PM
Allergies: NKA

RECEIVED
Date: 4-6-05
Time: 930
Receiving Nurse Intials [initials]

(S)ubjective: Runny nose, Coughing
(R) RPR - needs TX

(O)bjective (V/S): T: 97.9 P: 84 R: 24 BP: 120/60 WT: 135
M7 40 BMC Hx of C

(A)ssessment: Ccit in comfort R/T above statement

(P)lan: Entex PSE ÷ PO
Bicillin 2.4 mu IM q wk x 3
Medical Hold until P lasting

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN (circled)
CIRCLE ONE

Check One: ROUTINE (✓) EMERGENCY ( )

If Emergency was PHS supervisor notified: Yes ( ) No ( )

Was MD/PA on call notified: Yes ( ) No ( )

Graves, RN [signature]
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS
PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 3-24-05
ID # 238498 Date of Birth: [redacted] Location: W-22
Nature of problem or request: I am having problems urinating on my self - can't hold urine, I take medicine at home to help me -
Also - I need a pink slip for a key lock - I can't see well enough to open a combination lock - I wear glasses
X Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: 3/28/05
Time: 900 AM PM
Allergies: NKDA

RECEIVED
Date: 3-28-05
Time: 900A
Receiving Nurse Intials [illegible]

(S)ubjective: (1) I cant hold my water
(2) Soap has broken me out in my private Itches really bad

(O)bjective (V/S): T: 97' P: 76 R: 20 BP: 140/75 WT: 140
77 yo BM c̄ Hx of Stroke 10 to 12 yrs ago

(A)ssessment: Alt. in comfort R/T above statement

(P)lan: See NP

Refer to: MD/PA Mental Health Dental Daily Treatment ~~Return~~ to Clinic PRN
CIRCLE ONE
Check One: ROUTINE (✓) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

Graves, LPN [signature]
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS
PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 4/13/05 TIME 0030 (AM) PM

ORIGINATING FACILITY Kilby ☐ SIR ☐ PDL ☐ ESCAPEE ☐

☐ SICK CALL ☐ EMERGENCY ☑ OUTPATIENT

ALLERGIES NKA

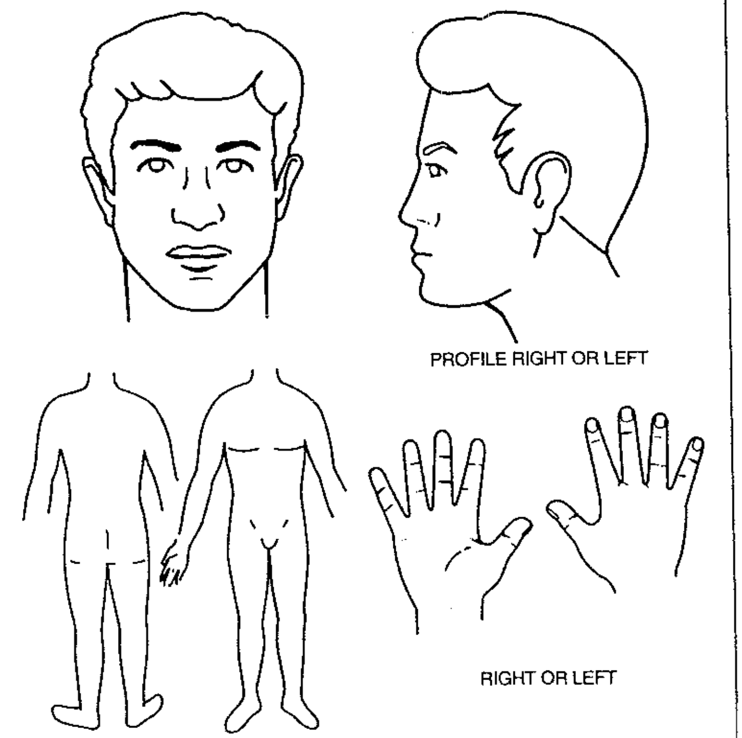
CONDITION ON ADMISSION ☐ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 99.1 (ORAL) RECTAL RESP 20 PULSE 88 B/P 100/70 RECHECK IF SYSTOLIC <100> 50

NATURE OF INJURY OR ILLNESS

S- c/o upset stomach, but states he feel better.
O- Alert & coherent, Resp unlabored, denies N&V.
Remain on naprosyn. States has been having bowel movements. (+) BS x4 quad.
No acute distress noted.
A: Por alt in comfort r/t DX
P: 30cc mylanta
Eat food while taking naprosyn

ABRASION /// CONTUSION # BURN xx xx FRACTURE Z Z LACERATION / ____ SUTURES



PHYSICAL EXAMINATION

Return if worsen

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY
Mylanta 30cc po	1230pm	AB

DIAGNOSIS

INSTRUCTIONS TO PATIENT Eat food c naprosyn - return if condition worsen

DISCHARGE DATE 4/13/05 TIME 1230 (AM) PM

RELEASE / TRANSFERRED TO ☑ DOC ☐ AMBULANCE ☐

CONDITION ON DISCHARGE ☑ SATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL

NURSE'S SIGNATURE A Brandon RN DATE 4/13/05 PHYSICIAN'S SIGNATURE [signature] 4/4/05 DATE CONSULTATION

INMATE NAME (LAST, FIRST MIDDLE)	DOC#	DOB	R/S	FAC
Brannon Lonnie	238498	[redacted]	B/m	Kilby

PHS
PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: LONIE CAMMON Date of Request: 3/20/05
ID # 238498 Date of Birth: [redacted] Location: ED
Nature of problem or request: STOMACH is heARting

Signature

DO NOT WRITE BELOW THIS LINE

Date: 3/21/05
Time: 715 (AM) PM
Allergies: NKA

RECEIVED
Date: 3-21-05
Time: 715AM
Receiving Nurse Intials n

(S)ubjective: Everytime I eat something my Chest & Head hurts

(O)bjective (V/S): T: 98.4 P: 60 R: 20 BP: 130/80 WT: 138
A+OX3. Resp reg c̄ ease. VS WNL NAD.
77 40 BM

(A)ssessment: Alt. in comfort R/T above statement

(P)lan: See NP

Refer to: MD/PA Mental Health Dental Daily Treatment (Return to Clinic PRN)
CIRCLE ONE
Check One: ROUTINE (✓) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

3/21/05
Pt. left before PE
Called x 6
F/u PRN

Graves, LPN
SIGNATURE AND TITLE

[signature], CRP

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Facility Name: Bullock Correctional Facility

Month/Year Charting: 07/06

Mevacor 40MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

1700 VS VS - D/c'd 06/02 - See Below

Start Date: 05-09-2006

Stop Date: 08-06-2006

Prescriber: Darbouze, Jean

RX #: 251492214

Aspirin EC 325MG EC Tab 30.00

Take 1 tablet(s) by mouth daily

1100 YM/M - See Below -

Start Date: 05-09-2006

Stop Date: 08-06-2006

Prescriber: Darbouze, Jean

RX #: 251492217

NitroQuick 0.4MG SL Tab (Bottle) 1

Dissolve one tablet under tongue as needed

K O P

Start Date: 05-09-2006

Stop Date: 08-06-2006

Prescriber: Darbouze, Jean

RX #: 251492225

Ditropan 5MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

D/C

Start Date: 05-09-2006

Stop Date: 08-06-2006

Prescriber: Darbouze, Jean

RX #: 251492231

Mevacor 20mg PO QD x 180 days

1700 [daily nurse initials]

Start Date: 06/02/06

Stop Date: 12/02/06

Prescriber: Dr. T Siddiq

RX #:

ASA 325mg PO QD x 180 days

1100 [daily nurse initials]

Start Date: 06/02/06

Stop Date: 12/02/06

Prescriber: Dr. T Siddiq

RX #:

Nurse's Signature	Initial	Nurse's Signature	Initial
V Smith LPN	VS	Martha Jackson LPN	MJ
		T. Appling LPN	TA
		Yolanda Mosley LPN	YM
		Peter Smith	PS

Diagnosis

Allergies: NKDA

Housing Unit: Population

Patient ID Number: 238498

Patient Name: **Cammon, Lonnie**

Date of Birth: [redacted]

Documentation Codes:
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9 No Show
10 Other

II g II II

Facility Name:

Month/Year of Charting:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Decadron 4mg Im q d x 3 days IM	9am								→	NT	fm			←																	
											1	2	3	←																	
Percogesic i PO tid x 10 days	0400	→										9	9	9	9	9	9	9	→				S								
	1100	→										NT		[illegible]	[illegible]	[illegible]		TA	→				T								
	1700	→										ps	ps	ps	ps	ps	ps	ps	ps				O								
																							P								
Prednisone 20mg i PO QD	1100	→																	TA	TA	9	TA	TA		TA		←				
Naprosyn 250mg i PO tid	0400	→																	9	9	9	9	9		9	9	9	9	9	9	9
	1100	→																	TA	TA	9	TA	TA			TA	9	9			9
	1700	→																	ps	ps	ps	ps	ps		9	9	9		9	9	
~~Prednisone 20mg i PO QD x 10 days~~ DC	1100	→																							→						
~~Naprosyn 250mg i PO TID x 15 days~~ DC	0400	→																								→					
	1100	→																							→						
	1700	→																							→						

Decadron — Start Date: 7/10/06 Stop Date: 7/13/06 Prescriber: Siddiq RX #:

Percogesic — Start Date: 7/10/06 Stop Date: 7/21/06 Prescriber: Siddiq RX #:

Prednisone — Start Date: 7/17/06 Stop Date: 7/26/06 Prescriber: Siddiq RX #:

Naprosyn — Start Date: 7/17/06 Stop Date: 8/01/06 Prescriber: Siddiq RX #:

Prednisone (crossed out, "Error") — Start Date: 7/25/06 Stop Date: 8/3/06 Prescriber: Siddiq RX #:

Naprosyn (crossed out, "Error") — Start Date: 7/25/06 Stop Date: 8/8/06 Prescriber: Siddiq RX #:

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Code
	J Appling LPN	TA	N Tolbert RN	NT	1 Discontinued Order
Allergies NKDA			Martha Jackson LPN	MJ	2 Refused
					3 Patient out of facility
Housing Unit:					4 Charted in Error
Patient ID Number: 238492			[signature]	PS	5 Lock Down
Patient Name: Cannon, Lonnie					6 Self Administered
			Date of Birth: [redacted]		7 Medication out of Stock
					8 Medication Held
					9 No Show
					10 Other

Facility Name: BCCF

Month/Year of Charting: 07/06

Decudron 4mg
Now in Elbow

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
0900																								→	K					

Start Date: 7/25/06 Prescriber: Siddiq
Stop Date: 7/25/06 RX #:

Start Date: Prescriber:
Stop Date: RX #:

Start Date: Prescriber:
Stop Date: RX #:

Start Date: Prescriber:
Stop Date: RX #:

Start Date: Prescriber:
Stop Date: RX #:

Start Date: Prescriber:
Stop Date: RX #:

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Code
					1 Discontinued Order
Allergies					2 Refused
					3 Patient out of facility
Housing Unit:					4 Charted in Error
Patient ID Number: 235498					5 Lock Down
Patient Name:					6 Self Administered
					7 Medication out of Sto
					8 Medication Held
Cammon Lonnie			Date of Birth		9 No Show
					10 Other

EXHIBIT A-2

Facility Name: Bullock

Month/Y... of Charting: 06/06

Decadron 4mg IM QD x 5 days

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22

11 00 NT

Start Date: 06/01/06 Prescriber: Dr. T. Siddiq

Stop Date: 06/05/06 RX #:

06/01/06 2100

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

ASA 1 p.o. qd x 180 Days

11A X NT 9 9 9 9 9 9 NR NA NA

Start Date: 6-2-06 Prescriber: Dr. Siddiq

Stop Date: 12-2-06 RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Mevacor 20mg p.o. qd x 180 Days

5P X NT 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9

Start Date: 6-2-06 Prescriber: Dr. Siddiq

Stop Date: 12-2-06 RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Decadron 4mg Im now

Start Date: 6 22 06 Prescriber: Siddiq

Stop Date: 6 22 06 RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Start Date: Prescriber:

Stop Date: RX #:

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Start Date: Prescriber:

Stop Date: RX #:

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial
	Appling LPN	TP	N. Tolbert, RN	RN
Allergies NKDA				BJ
Housing Unit:				
Patient ID Number 238498				
Patient Name:				PS
Common Lonnie			Date of Birth: [redacted]	

Documentation Code
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7. Medication out of Sto
8 Medication Held
9. No Show
10 Other

Prison Health Services

REFUSAL OF TREATMENT FORM

Institution: Bullock

Resident's Name: Lonnie Cammon ID# X 238498

D.O.B. [redacted]

I, Lonnie Cammon (Name of Inmate) have, this day, knowing that I have a condition requiring medical care as indicated below:

___	A.	Refused medication.	___	E.	Refused X-Ray services.
___	B.	Refused dental care.	___	F.	Refused other diagnostic tests
___	C.	Refused an outside medical appointment.	___	G.	Refused physical examination.
___	D.	Refused laboratory services.	___	H.	Other (Please specify)

Reason For Refusal The Medication is not doing any good

Potential Consequences Explained yes

I acknowledge that I have been fully informed of and understand the above treatment recommendations and the risks involved in refusing them. I hereby release and agree to hold harmless the state, statutory authority, all correctional personnel, medical/health personnel from all responsibility and any ill effects which may result from this refusal and I shall personally assume responsibility for my welfare.

I have read this form and certify that I understand its contents.

Linda Anderson
Witness Signature

Martha Dotson
Witness Signature

X Lonnie Cammon
Patient Signature

6-26-06
Date

0600
Time

NOTE: A refusal by the resident to sign requires the signatures of at least one witness in addition to that of the medical staff member.

PHS MD-70108

Facility Name:

Month/Year of Charting:

Mevacor 40mg i tab po Bid

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
4a								9	9	9	9							9											[illegible]	[illegible]
4P																												[illegible]	[illegible]	

Start Date: 5-7-06 Prescriber: Darbouze
Stop Date: 8-7-06 RX #

Aspirin EC 325mg i po QD

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
4A								9	9	9	9							9											[illegible]	[illegible]

Start Date: 5-7-06 Prescriber: Darbouze
Stop Date: 8-7-06 RX #

Nitroglycerin 0.4mg SL prn

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
K																														
O																														
P				i		3-4-06																								

Start Date: 5-7-06 Prescriber: Darbouze
Stop Date: 8-7-06 RX #

Ditropan 5mg i po Bid

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
4a								9	P	9	9							9											1	[illegible]
4P																												[illegible]	[illegible]	

Start Date: 5-7-06 Prescriber: Darbouze
Stop Date: 8-7-06 RX #

Tylenol 325mg ii p.o. bid x 3 days PRN

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
4A	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	[illegible]	[illegible]
4p	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	[illegible]	[illegible]	[illegible]

Start Date: 5/27/06 Prescriber: Darbouze/LE
Stop Date: 6/30/06 RX #

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date: Prescriber:
Stop Date: RX #

Diagnosis

Allergies NKDA

Housing Unit:
Patient ID Number: 238498
Patient Name:
Cameron Connie

Nurse's Signature	Initial	Nurse's Signature	Initial
S. [illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	S. [illegible]	[illegible]

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9 No Show
Other

[redacted]

Facility Name:

Month/Yr. Charting:

KCl 10mg po QD x 7 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
4A	—	—	—	—																										

ERROR

Start Date: 5-6-06 Prescriber: [signature]
Stop Date: 5-12-06 RX #:

Bactrim D/S T po Bid x10

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
4A	—	—		4/98				9	9	9	9																			
4p	—	C	N	√																										

Start Date: 5-2-06 Prescriber: D. Floyd
Stop Date: 5-12-06 RX #

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date: Prescriber
Stop Date: RX #.

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date. Prescriber.
Stop Date RX #

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date: Prescriber.
Stop Date: RX #

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date: [signature] Prescriber:
Stop Date: RX #.

Diagnosis

Allergies

Housing Unit:
Patient ID Number:
Patient Name: Cammon Lonnie [redacted]

Nurse's Signature	Initial	Nurse's Signature	Initial
S. Barber	SB	[signature]	[illegible]
[signature]	[illegible]	L. Collins	LC
		M. Harper	MP
		J. Smith	[illegible]

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9 No Show
10. Other

Facility Name: ~~Easterling Correctional Fac~~

Month of Charting: 05/06

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Isordil Titradose 5MG Tab 90.00

Take 1 tablet(s) by mouth Three Times Daily

DC'd 1-29-06

Start Date: 02-06-2006 Prescriber: Darbouze, Jean

Stop Date: 05-06-2006 RX #: 251146619

Mevacor 40MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

4a $ $ $ See new Ord

4p D/C

Start Date: 03-02-2006 Prescriber: Darbouze, Jean

Stop Date: 05-30-2006 RX #: 251235291

Aspirin EC 325MG EC Tab 30.00

Take 1 tablet(s) by mouth daily

4a $ $ See new Ord

Start Date: 03-07-2006 Prescriber: Darbouze, Jean

Stop Date: 06-04-2006 RX #: 251254454

Nitroglycerin 0.4MG SL Tab (Bottle) 1

Dissolve one tablet under tongue as needed for chest pain as directed

B

O

P T 3-4-06 See new Ord

Start Date: 03-07-2006 Prescriber: Darbouze, Jean

Stop Date: 06-04-2006 RX #: 251255731

Ditropan 5MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

4a $ $ See new Ord

4p D/C

Start Date: 03-07-2006 Prescriber: Darbouze, Jean

Stop Date: 06-04-2006 RX #: 251254458

LASIX 40mg PO

4a

ERROR

Start Date: 5-6-06 Prescriber:

Stop Date: 5-12-06 RX #:

Diagnosis

Allergies

Housing Unit: Population

Patient ID Number: 238498

Patient Name: **Cammon, Lonnie**

Nurse's Signature	Initial	Nurse's Signature	Initial
			NP

Date of Birth [redacted]

Documentation Codes

1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9 No Show
10 Other

Facility Name: Easterling Correctional Facility — Month/Year of Charting: 04/06

zantac 150MG Tab 60 00

Take 1 tablet(s) by mouth twice daily

Hour: 6a X, X; 6p X, X

Start Date: 01-05-2006 — Prescriber: Darbouze, Jean

Stop Date: 04-04-2006 — RX #: 251038965

Tylenol 500MG Tab 180 00

Take 2 tablet(s) =1000mg by mouth Three Times Daily as needed

Hour: 6a, 9a, 6p

Start Date: 01-25-2006 — Prescriber: Darbouze, Jean

Stop Date: 04-24-2006 — RX #: 251105412

Isordil Titradose 5MG Tab 90.00

Take 1 tablet(s) by mouth Three Times Daily

D/C'd 1-29-06

Start Date: 02-06-2006 — Prescriber: Darbouze, Jean

Stop Date: 05-06-2006 — RX #: 251146619

Mevacor 40MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

Hour: 6a, 6p

Start Date: 03-02-2006 — Prescriber: Darbouze, Jean

Stop Date: 05-30-2006 — RX #: 251235291

Aspirin EC 325MG EC Tab 30 00

Take 1 tablet(s) by mouth daily

Hour: 6a

Start Date: 03-07-2006 — Prescriber: Darbouze, Jean

Stop Date: 06-04-2006 — RX #: 251254454

Nitroglycerin 0 4MG SL Tab (Bottle) 1

Dissolve one tablet under tongue as needed for chest pain as directed

3-4-06

Start Date: 03-07-2006 — Prescriber: Darbouze, Jean

Stop Date: 06-04-2006 — RX #: 251255731

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial
Allergies				
Population				
Housing Unit: 238498				
Patient ID Number:				
Patient Name: **Cammon, Lonnie**			Date of Birth: [redacted]	

Documentation Code

1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stc
8 Medication Held
9 No Show
10. Other

Facility Name: Easterling Correctional Facility

Month/Year of Charting: 04/06

Hour: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Ditropan 5MG Tab 60 00

Take 1 tablet(s) by mouth twice daily

4A

4P

Start Date: 03-07-2006 Prescriber: Darbouze, Jean

Stop Date: 06-04-2006 RX #: 251254458

Prednisone 20mg po qd x 5 d

4A D/C'd 04

4P D/C'd 04

Start Date: 3-29-04 Prescriber: Darbouze

Stop Date: 4-3-04 RX #:

Feldene 20mg po qpm x 30 d

4P D/C'd 04

X X X X

Start Date: 3-23-04 Prescriber: Darbouze

Stop Date: 4-23-04 RX #:

Naprosyn 375mg po Bid X 14 days

4A

4P

Start Date: 4-5-06 Prescriber: Darbouze

Stop Date: 4-19-06 RX #:

Lasix 40mg po qd x 7

4A

Start Date: 5-6-06 Prescriber: Darbouze

Stop Date: 5-12-06 RX #:

Kcl 10 mg po qd x 7

4A

Start Date: 5-6-06 Prescriber: Darbouze

Stop Date: 5-12-06 RX #:

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Code
Allergies					1 Discontinued Order 2 Refused 3 Patient out of facility 4 Charted in Error 5 Lock Down 6 Self Administered 7 Medication out of Stc 8 Medication Held 9 No Show 10 Other

Housing Unit: Population 238498

Patient ID Number:

Patient Name: **Cammon, Lonnie**

Date of Birth: [redacted]

Facility Name:

Month/Year of Charting:

Cosopt 0.5% i gtt each eye Bid

Hour: K / O / P

Start Date: 12-31-05
Stop Date: 4-11-06
Prescriber: Darbouze
RX #:

MevaCor 40mg Take i tab po Bid

Hour: 4A / 4P

Start Date: 3-1-06
Stop Date: 6-1-06
Prescriber: Darbouze/SB
RX #:

Naproxen 375mg i po Bid prn x 10 days

Hour: 4A / 4P

DC 3/3

Start Date: 2-7-06
Stop Date: 3-8-06
Prescriber: Darbouze
RX #:

Prednisone 20mg po bid x 5days Then

Hour: 4a / 4p

Start Date: 3/3/06
Stop Date: 3/8/06
Prescriber: Darbouze/NP
RX #:

Prednisone 20mg po Qd x 5days

Hour: 4a / 4p

Start Date: 3/8/06
Stop Date: 3/13/06
Prescriber: Darbouze/NP
RX #:

EC ASA 325mg i po qd X 90 days

Hour: 4A

Start Date: 3-6-06
Stop Date: 6-6-06
Prescriber: Darbouze
RX #:

Diagnosis:

Allergies: NKDA

Housing Unit:

Patient ID Number: 238498

Patient Name: Cammon, Lonnie

Nurse's Signature	Initial	Nurse's Signature	Initial
S. Baker RN	SB	S. Smith	SS
[illegible]	[illegible]	M. Wayne RN	MW

Documentation Code
1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stoc
8. Medication Held
9. No Show
Other

Date of Birth: [redacted]

Facility Name: Easterling Correctional Facility — Month/Year of Charting: 03/06

zantac 150MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

Start Date: 01-05-2006 — Prescriber: Darbouze, Jean
Stop Date: 04-04-2006 — RX #: 251038965

Aspirin EC 325MG EC Tab 30.00

Take 1 tablet(s) by mouth daily

Start Date: 01-14-2006 — Prescriber: Darbouze, Jean
Stop Date: 04-13-2006 — RX #: 251074186

Tylenol 500MG Tab 180.00

Take 2 tablet(s) =1000mg by mouth Three Times Daily as needed

Start Date: 01-25-2006 — Prescriber: Darbouze, Jean
Stop Date: 04-24-2006 — RX #: 251105412

Nitroglycerin 0.4MG SL Tab (Bottle) 1

Dissolve one tablet under tongue as needed for chest pain

Start Date: 02-06-2006 — Prescriber: Darbouze, Jean
Stop Date: 05-06-2006 — RX #: 251146618

Isordil Titradose 5MG Tab 90.00

Take 1 tablet(s) by mouth Three Times Daily

D/c'd on 1-29-06

Start Date: 02-06-2006 — Prescriber: Darbouze, Jean
Stop Date: 05-06-2006 — RX #: 251146619

Ditropan 5MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

Start Date: 02-09-2006 — Prescriber: Darbouze, Jean
Stop Date: 05-09-2006 — RX #: 251160272

Diagnosis

Allergies NKDA

Housing Unit: Population
Patient ID Number: 238498
Patient Name: **Cammon, Lonnie**

Nurse's Signature	Initial	Nurse's Signature	Initial
		M Payne RN	MP

Documentation Code
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stoc
8 Medication Held
9 No Show
10 Other

T. Pa II

Date of Birth: [redacted]

Facility Name: East

Month/Year Charting: 3-06

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Prednisone 20mg po ~~q[illegible] x 3~~ Bid X 5 days	4A																							[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
	4P																							[illegible]	[illegible]	R	[illegible]	[illegible]			

Start Date: 3-23-06 Prescriber: Dabaye

Stop Date: 3-28-06 RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
↓ Prednisone to 20mg po qd X 5	4A																													S	

Start Date: 3-29-06 Prescriber: Dabouze

Stop Date: 4-3-06 RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date: Prescriber:

Stop Date: RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date: Prescriber:

Stop Date: RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date. Prescriber:

Stop Date: RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date Prescriber:

Stop Date. RX #:

Diagnosis

Allergies NKA

Housing Unit:

Patient ID Number: 238498

Patient Name: Camman Lonnie

Nurse's Signature	Initial	Nurse's Signature	Initial
[illegible] R	R		

Date of Birth. [redacted]

Documentation Code
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stoc
8 Medication Held
9. No Show
10 Other

Facility Name: EASTERLING

Month/Charting: MAR '06

Medication	Hour	Days 1–30
NTG 0.4mg S/L PRN AS DIRECTED FOR CHEST PAIN	KOP	i GIVEN 3-4-06 ; i GIVEN 2-17-06
Start Date: 3-3-06	Prescriber: Darbouze	
Stop Date: 6-3-06	RX #:	
DITROPAN 5mg i PO BID X 90 days	4A	[handwritten initials]
	4P	[handwritten initials]
Start Date: 3-3-06	Prescriber: Darbouze	
Stop Date: 6-3-06	RX #:	
Miconazol Cr Bid x 30days	4A / 4p	tube 3-9-06
Start Date: 3/9/06	Prescriber: DR Darbouze	
Stop Date: 4/9/06	RX #:	
Lasix 40mg i PO QD x 5days	4A	[handwritten initials]
Start Date: 3/9/06	Prescriber: Dr Darbouze	
Stop Date: 3/14/06	RX #:	
KCL 10meq i PO QD x 5days	4A	[handwritten initials]
Start Date: 3/9/06	Prescriber: Dr Darbouze	
Stop Date: 3/14/06	RX #:	
Feldene 20mg PO qpm x 30	4P	[handwritten initials]
Start Date: 3-23-06	Prescriber: Darbouze	
Stop Date: 4-23-06	RX #:	

Diagnosis: [circled] PO III

Allergies: NKDA

Housing Unit:

Patient ID Number: 238498

Patient Name: CAMMON, LONNIE

Nurse's Signature	Initial	Nurse's Signature	Initial
[signature]	SS	KCPayne RN	KP
[signature]	[initial]		

Date of Birth [redacted]

Documentation Code
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stoc
8 Medication Held
9 No Show
10 Other

Facility Name: Easterling

Month/Year Charting: 2/06

Ditropan 5mg i po Bid x 90 days

Hour: 4A, 4P — [illegible initials, days 1–27]

Start Date: 1-13-06 | Prescriber: Darbouze
Stop Date: 4-13-06 | RX #:

Isordil 5mg tabs i po tid x 90 days

Hour: 4A, 9A, 4P — D/C'd 2-4-06

Start Date: 1-19-06 | Prescriber: Darbouze
Stop Date: 3-19-06 | RX #:

Nitroglycerin 150mg subling tab i As needed

i Bottle given 1-19-2006 — See new order 2/15

Start Date: 1-19-06 | Prescriber: Darbouze
Stop Date: 3-19-06 | RX #:

Cosopt 0.5% i gtt ea eye BID

Hour: KOP

Start Date: 12-31-05 | Prescriber: Darbouze
Stop Date: 4-11-06 | RX #:

Naproxen 375mg bid PRN x 10 days

Hour: 4A, 4P — → [illegible initials, days 7–14] — See new order 2/15

Start Date: 2/7/06 | Prescriber: Darbouze
Stop Date: 2/17/06 | RX #:

Colchicine 0.6mg QD x 10 days

Hour: 4A — → [illegible initials, days 7–14] — DC 2/15/06

Start Date: 2/7/06 | Prescriber: Darbouze
Stop Date: 2/17/06 | RX #:

Diagnosis:

Allergies: NKDA

Housing Unit:
Patient ID Number: 238498
Patient Name: Cannon, Lonnie II

Nurse's Signature	Initial	Nurse's Signature	Initial
[illegible]		J. Smith	S
[illegible]			
S. McKinna	S	L. Ewing LPN	LE
M. Moore LPN	M	[illegible]	LR

Date of Birth: [redacted]

Documentation Code:
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stoc
8 Medication Held
9 No Show
10 Other

Facility Name: Easterling Correctional Facility — Month/Year Charting: 02/06

Hour: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Artificial Tears 1.4% Solution 1

Use as directed

Start Date: 08-10-2005 — Prescriber: Bradford, Michael

Stop Date: 02-05-2006 — RX #: 250378959

Mevacor 40MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

Start Date: 08-27-2005 — Prescriber: Darbouze, Jean

Stop Date: 02-22-2006 — RX #: 250502508

zantac 150MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

Start Date: 01-05-2006 — Prescriber: Darbouze, Jean

Stop Date: 04-04-2006 — RX #: 251038965

Aspirin EC 325MG EC Tab 30.00

Take 1 tablet(s) by mouth daily

Start Date: 01-14-2006 — Prescriber: Darbouze, Jean

Stop Date: 04-13-2006 — RX #: 251074186

tylenol 1gm PO tid PRN x 90 days

Start Date: 1-23-06 — Prescriber: Pinkard

Stop Date: 4-23-06 — RX #:

M. Conazole Cr. topically B.i.d x 14 days

1 tube given 1-24-06

Start Date: 1-23-06 — Prescriber: Barbour

Stop Date: 2-7-06 — RX #:

Diagnosis

Allergies NKDA

Housing Unit: Population

Patient ID Number: 238498

Patient Name: **Cammon, Lonnie** I

Nurse's Signature	Initial	Nurse's Signature	Initial
[illegible]		[illegible]	SS
[illegible]		[illegible]	
[illegible]		L Ewing LPN	LE
[illegible]		[illegible]	JH

Date of Birth [redacted]

Documentation Code:
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9 No Show
Other

Facility Name: ECF

Month/Year of Charting: 2/06

Medication	Hour	1–14	15–30
Naproxen 375mg ÷ po bid x 14 days PRN	4a	→	[illegible initials]
	4p	→	[illegible initials]
			NEW order 2/27

Start Date: 2/15/06 Prescriber: Darbouze/NP
Stop Date: 3/1/06 RX #:

Medication	Hour	Administration
NTG SL PRN (0.4mg) x 100 days		① Bottle given 2-17-06
		① Bottle given 1/19/06

Start Date: 2/15/06 Prescriber: Darbouze/NP
Stop Date: 3/25/06 RX #:

Medication	Hour	1–26	27
Naproxen 375mg PO BID PRN x 14 days	4a	→	
	4p	→	[illegible initials]

Start Date: 2-7-06 Prescriber:
Stop Date: RX #:

Hour 1–30 (blank)

Start Date: Prescriber:
Stop Date: RX #:

Hour 1–30 (blank)

Start Date: Prescriber:
Stop Date: RX #:

Hour 1–30 (blank)

Start Date: Prescriber:
Stop Date: RX #:

Diagnosis

Allergies: NKA

Housing Unit:

Patient ID Number: 238498

Patient Name: Cammon, Lonnie III

Nurse's Signature	Initial	Nurse's Signature	Initial
M Payne RN	MP	J. Knott	S
M. Morales LPN	MM	R. Ewing LPN	RE

Date of Birth: [redacted]

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stoc
8 Medication Held
9 No Show
10 Other

Facility Name: Easterling — Month/Year Charting: JAN

Hour: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Zantac 150mg ± PO BID x 90d

Start Date: 4/3/06 — Stop Date: 4/3/06 — Prescriber: Dr Darby — RX #:

Tylenol 650mg PO tid PRN x 90 days

Start Date: 1-23-06 — Stop Date: 4-23-06 — Prescriber: Dabours — RX #:

Miconazole 9 topically BID x 14 days

Start Date: 1-23-06 — Stop Date: 2-7-06 — Prescriber: Dabours — RX #:

Feldene 20mg PO QPM x 5 days

Start Date: 1-23-06 — Stop Date: 1-27-06 — Prescriber: Dabours — RX #:

Bengay topically BID x 5 days PRN

Start Date: 1-24-06 — Stop Date: 1-28-06 — Prescriber: Dabours — RX #:

Start Date: — Stop Date: — Prescriber: — RX #:

Diagnosis

Allergies NKDA

Housing Unit:

Patient ID Number:

Patient Name: CAMPBELL LONNIE

Nurse's Signature	Initial	Nurse's Signature	Initial
[illegible]	[illegible]	[illegible]	[illegible]

Date of Birth: [redacted]

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9. No Show
10 Other

Facility Name: Easterling Correctional Facili | Month/Ye | Charting: 01/06

Hour: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Artificial Tears 1 4% Solution 1

Use as directed

K
O
P

Start Date: 08-10-2005 Prescriber: Bradford, Michael
Stop Date: 02-05-2006 RX #: 250378959

Aspirin EC 325MG EC Tab 30.00

Take 1 tablet(s) by mouth daily

4a 9 [illegible] See new order

Start Date: 08-27-2005 Prescriber: Darbouze, Jean
Stop Date: 02-22-2006 RX #: 250502541

Ditropan 5MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

4a 9 [illegible]
4p [illegible] See new order

Start Date: 08-27-2005 Prescriber: Darbouze, Jean
Stop Date: 02-22-2006 RX #: 250502523

Mevacor 40MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

4a 9 [illegible]
4p [illegible] See new order

Start Date: 08-27-2005 Prescriber: Darbouze, Jean
Stop Date: 02-22-2006 RX #: 250502508

Cosopt 0.5%

1 gtt each eye bid

K
O
P

Start Date: 12/31/05 Prescriber: Darbouze
Stop Date: 4/11/06 RX #:

Tylenol 500mg

1 po bid

4A 9 [illegible]
4P [illegible] See new order

Start Date: 11-17-05 Prescriber: Darbouze
Stop Date: 2-17-06 RX #:

Diagnosis

Allergies

NKA

Housing Unit: Population
Patient ID Number: 238498
Patient Name:

Cammon, Lonnie

Nurse's Signature	Initial	Nurse's Signature	Initial
Hawkins LPN	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]

Date of Birth: [redacted]

Documentation Code
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stoc
8. Medication Held
o Show
Other

Facility Name: EASTERLING

Month/Year Charting: JAN 06

Medication	Hour	Start Date	Stop Date	Prescriber	RX #
EC ASA 325mg ÷ po qd x 90 days	4A	1-13-06	4-13-06	Darbouze	
DITROPAN 5mg ÷ po BID x 90 days	4A, 4P	1-13-06	4-13-06	Darbouze	
Mevacor 40mg ÷ po BID x 90 days	4A, 4P	1-13-06	4-13-06	Darbouze	
Isordil 5mg TAB ÷ po TID X 90 days	4A, 9A, 4P	1-15-2006	3-19-2006	Darbouze / Darbouze	
Nitroglycerin 1/150 mg Sublingual TAB ÷ po As needed — 1 Bottle 1-19-2006		1-19-2006	3-19-2006	Darbouze / Darbouze	
↑ Isordil to 10mg po tid x 90 days	4A, 9A, 4P	1-23-06	4-23-06	Darbouze	

Isordil 5mg: See new order

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial
PGII	S. Smoot	SRS	[illegible]	R
Allergies: NKDA	S. Baker	SB		
Housing Unit:	Maulie Moates LPN	MM		
Patient ID Number: 238498			[illegible] LPN	[illegible]
Patient Name: CAMMON, LONNIE			Date of Birth: [redacted]	

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9. No Show
10 Other

Facility Name: Easterling Correctional Facili,

Month/Year of Charting: 12/05

Cosopt 2-0.5% Solution 1

Place 1 drop(s) in each eye twice daily

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
K																														
o																														
P																														

Start Date: 06-30-2005 Prescriber: Robbins, Michael
Stop Date: 12-26-2005 RX #: 250090355

Artificial Tears 1.4% Solution 1

Use as directed

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
K																														
o																														
P																														

Received + 8/10/05

Start Date: 08-10-2005 Prescriber: Bradford, Michael
Stop Date: 02-05-2006 RX #: 250378959

Aspirin EC 325MG EC Tab 30.00

Take 1 tablet(s) by mouth daily

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
4A	[illegible]	[illegible]	[illegible]	R	9	9	[illegible]	9	9	9	[illegible]	[illegible]	[illegible]	9	[illegible]	[illegible]	9	9	9	R	9	[illegible]	[illegible]	9	9	9	9	[illegible]	[illegible]	[illegible]

Start Date: 08-27-2005 Prescriber: Darbouze, Jean
Stop Date: 02-22-2006 RX #: 250502541

Ditropan 5MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
4A	[illegible]	[illegible]	[illegible]	R	9	9	[illegible]	9	9	9	[illegible]	[illegible]	[illegible]	[illegible]	9	[illegible]	9	9	9	R	9	[illegible]	[illegible]	9	9	9	9	[illegible]	[illegible]	[illegible]
4P	[illegible]	9	9	[illegible]	[illegible]	9	R	9	9	9	[illegible]		9	[illegible]		[illegible]	[illegible]	[illegible]	7	[illegible]		[illegible]	[illegible]		[illegible]		[illegible]	[illegible]		[illegible]

Start Date: 08-27-2005 Prescriber: Darbouze, Jean
Stop Date: 02-22-2006 RX #: 250502523

Mevacor 40MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
4A	[illegible]	[illegible]	[illegible]	9	9	9	[illegible]	9	9	9	[illegible]	[illegible]	[illegible]	9	[illegible]	[illegible]	9	9	9	R	[illegible]	[illegible]	[illegible]	9	9	9	9	[illegible]	[illegible]	[illegible]
4P	[illegible]	9	9	[illegible]	[illegible]	9	R	9	9	9	[illegible]		[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]		[illegible]		[illegible]	9		[illegible]

Start Date: 08-27-2005 Prescriber: Darbouze, Jean
Stop Date: 02-22-2006 RX #: 250502508

Tyenol + gram PO
Bid X 90 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
4A	[illegible]	[illegible]	[illegible]	R	9	9	[illegible]	9	9	9	[illegible]	[illegible]	[illegible]	9	[illegible]	9	9	9	9	R	9	[illegible]	[illegible]	9	9	9	9	[illegible]	[illegible]	[illegible]
4P	[illegible]	9	[illegible]	[illegible]	[illegible]	9	[illegible]	9	9	9	[illegible]		[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		[illegible]	[illegible]		[illegible]		[illegible]	[illegible]		[illegible]

Start Date: 11/17/05 Prescriber: Darbouze /SB
Stop Date: 2-17-06 RX #:

Nurse's Signature	Initial	Nurse's Signature	Initial
[illegible]	[illegible]	S. Smoltz	SES
C Wamely	CW	C Garcia LPN	[illegible]
L. Ewing LPN	LE	[illegible]	CM
		[illegible]	[illegible]

Diagnosis

Allergies

Housing Unit: Population

Patient ID Number: 238498

Patient Name: **Cammon, Lonnie**

Date of Birth: [redacted]

Documentation Code
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stoc
8 Medication Held
9. No Show
0 Other

Facility Name: EASterling

Month/Year Charting: 11/05

Miconazole to inguinal area BID x 14 days

Hour: K / P — Recieved 10/25/05

Start Date: 10/25/05 — Prescriber: Dr. Darbouze/SB

Stop Date: 11/8/05 — RX #:

Peroxyl c H po TID PRN x 90 days

Hour: 4a / 9A / 4p — D/C 11/17/05

Start Date: 10/25/05 — Prescriber: Dr. Darbouze/SB

Stop Date: 1/25/05 — RX #:

Tylenol 1g P.O bid PRN x 90 days

Hour: 4a / 4p

Start Date: 11/17/05 — Prescriber: Darbouze

Stop Date: 2-17-06 — RX #:

Start Date: — Prescriber:

Stop Date: — RX #:

Start Date: — Prescriber:

Stop Date: — RX #:

Start Date: — Prescriber:

Stop Date: — RX #:

Diagnosis

Allergies: NKDA

Housing Unit:

Patient ID Number: 238458

Patient Name: Cannon Lonnie II

Nurse's Signature	Initial	Nurse's Signature	Initial
[illegible]	[illegible]	S. [illegible]	SW
M. [illegible] LPN	MP	L. Ewing	LE
SMcKinnon LR	[illegible]		
		[illegible]	[illegible]

Date of Birth [redacted]

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9. No Show
10. Other

Facility Name: Easterling Correctional Facili

Month/Y Charting: 11/05

Medication	Hour	Days 1–30	Start Date	Stop Date	Prescriber	RX #
Cosopt 2-0.5% Solution 1 — Place 1 drop(s) in each eye twice daily	KOP		06-30-2005	12-26-2005	Robbins, Michael	250090355
Artificial Tears 1.4% Solution 1 — Use as directed	KOP	Recieved Ṫ 8/10/05	08-10-2005	02-05-2006	Bradford, Michael	250378959
Aspirin EC 325MG EC Tab 30.00 — Take 1 tablet(s) by mouth daily	4A	[handwritten initials, days 1–30]	08-27-2005	02-22-2006	Darbouze, Jean	250502541
Ditropan 5MG Tab 60.00 — Take 1 tablet(s) by mouth twice daily	4A / 4P	[handwritten initials]	08-27-2005	02-22-2006	Darbouze, Jean	250502523
Mevacor 40MG Tab 60.00 — Take 1 tablet(s) by mouth twice daily	4A / 4P	[handwritten initials]	08-27-2005	02-22-2006	Darbouze, Jean	250502508
Acetaminophen 500MG Tab 120.00 — Take 2 tablet(s) =1gm by mouth twice daily as needed		D/c'd 10/25/05	08-27-2005	11-24-2005	Darbouze, Jean	250502522

Diagnosis

Allergies

Housing Unit: Population

Patient ID Number: 238498

Patient Name:

Cammon, Lonnie I

Nurse's Signature	Initial	Nurse's Signature	Initial
[signature]		S. [signature]	SPS
[signature]	MP	[signature]	[initials]
SMcKinnon	[initials]	L. Ewing LPN	LE
[signature]	[initials]	[signature]	[initials]

Date of Birth: [redacted]

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stocl
8 Medication Held
9 No Show
10 Other

Facility Name: Easterling Correctional Facility

Month/Year of Charting: 10/05

Medication	Details
Cosopt 2-0.5% Solution 1 Place 1 drop(s) in each eye twice daily	Start Date: 06-30-2005 Stop Date: 12-26-2005 Prescriber: Robbins, Michael RX #: 250090355
Artificial Tears 1.4% Solution 1 Use as directed	Rec 8-10-05 Start Date: 08-10-2005 Stop Date: 02-05-2006 Prescriber: Bradford, Michael RX #: 250378959
Aspirin EC 325MG EC Tab 30.00 Take 1 tablet(s) by mouth daily	Hour: 4A Start Date: 08-27-2005 Stop Date: 02-22-2006 Prescriber: Darbouze, Jean RX #: 250502541
Ditropan 5MG Tab 60.00 Take 1 tablet(s) by mouth twice daily	Hour: 4A, 4P Start Date: 08-27-2005 Stop Date: 02-22-2006 Prescriber: Darbouze, Jean RX #: 250502523
Mevacor 40MG Tab 60 00 Take 1 tablet(s) by mouth twice daily	Hour: 4A, 4P Start Date: 08-27-2005 Stop Date: 02-22-2006 Prescriber: Darbouze, Jean RX #: 250502508
Acetaminophen 500MG Tab 120.00 Take 2 tablet(s) =1gm by mouth twice daily as needed	Hour: 4A, 4P D/C 10/25/05 Start Date: 08-27-2005 Stop Date: 11-24-2005 Prescriber: Darbouze, Jean RX #: 250502522

Diagnosis

Allergies: NKDA

Housing Unit: Population

Patient ID Number: 238498

Patient Name:

Cammon, Lonnie

Nurse's Signature	Initial	Nurse's Signature	Initial
[illegible]	[illegible]	S. [illegible]	SFS
L. Ewing LPN	LE	[illegible] RN	MP
		[illegible]	8
		[illegible]	

Date of Birth: [redacted]

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
No Show
Other

Facility Name:

Month/Year Charting:

Medication	Hour	1–31
HC cream (hydrocortisone 1%) to affected areas BID + 7days	4A	→ (line drawn through day 23)
	4P	→ X Bonnie Cammon 10-25-205 [illegible]
	Start Date: 10/24/05	Prescriber: Darbouze MD
	Stop Date: 10/31/05	RX #:
Miconazole to inguinal area BID X 14 days	6	
	6p	X Bonnie Cammon 10-25-205 [illegible]
	Start Date: 10/25/05	Prescriber: Darbouze
	Stop Date: 11/8/05	RX #:
Percogesic ii PO TID PRN X 90 days	4A	→ / 9 [illegible]
	9A	→ / [illegible] LE
	4pm	→ / [illegible]
	Start Date: 10/25/05	Prescriber: Darbouze
	Stop Date: 1/25/06	RX #:
	Hour	
	Start Date:	Prescriber:
	Stop Date:	RX #:
	Hour	
	Start Date:	Prescriber:
	Stop Date:	RX #:
	Hour	
	Start Date:	Prescriber:
	Stop Date:	RX #:

Diagnosis

Allergies NKDA

Housing Unit:

Patient ID Number: 238498

Patient Name:

Cammon, Lonnie TT

Nurse's Signature	Initial	Nurse's Signature	Initial
L. Ewing LPN	LE	S Bushea	SB

Date of Birth: [redacted]

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8. Medication Held
No Show
Other

Facility Name:

Month/Year Charting:

Medication	Start Date	Stop Date	Prescriber	RX #
Cosopt 2%/0.5% Sol. i gtt in each eye Bid	6-30-05	12-26-05	Robbins	250090355
Artifical tears x180 days prn Adm. 30 min. p Cosopt x180 days (Re 8-10-05)	8-5-05	2-28-06	Robbins	
EC ASA 325mg po qd x180 days (Hour: 4A)	8-25-05	2-24-06	Darbouze	
Ditropan 5mg po Bid x 180 days (Hour: 4A, 4P)	8-25-05	2-24-06	Darbouze	
Mevacor 40mg po Bid x 180 days (Hour: 4A, 4P)	8-25-05	2-24-06	Darbouze	
Tylenol 1gm po Bid prn x 90 days (Hour: 4A, 4P)	8-25-05	11-25-05	Darbouze	

Hour: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Diagnosis:

Allergies: NKDA

Housing Unit:

Patient ID Number: 238496

Patient Name: Cammon Connie

Date of Birth [redacted]

Nurse's Signature	Initial	Nurse's Signature	Initial
[illegible signature]	[illegible]	[illegible signature]	[illegible]
[illegible signature]	[illegible]	[illegible signature]	[illegible]
		S Bushier	SB

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9. No Show
10 Other

Easterling

Facility Name:

Month/Year of Charting:

Order	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Cosopt i gtt OD/OS BID x 180 days	0900																															
06/24/05 12/24/05	1600																															

Start Date: Prescriber:

Stop Date: RX #:

Order	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Order	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Order	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Order	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Order	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Diagnosis

Allergies: NKA

Housing Unit: Population

Patient ID Number: 238498

Patient Name: Cammon, Lonnie

Nurse's Signature	Initial	Nurse's Signature	Initial
Bernice Dorkson	BD	B. Anderson LPN	BA
A. Willis	AW		
[illegible]	[illegible]	R. Frank RN	RF

Date of Birth:

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9 No Show
10 Other

Facility Name: Kilby Correctional Facility

Month/Year of Charting: 08/05

Received at ECF on 8-22-05

Medication	Hour	Administration (days 1–31)
Cosopt 2-0 5% Solution 1 Place 1 drop(s) in each eye twice daily	W W	
Start Date: 06-30-2005 · Stop Date: 12-26-2005	Prescriber: Robbins, Michael	RX #: 250090355
Ditropan 5MG Tab 60.00 Take 1 tablet(s) by mouth twice daily	06:00 18:00	[illegible initials, days 1–22] · See New Orders 8/25
Start Date: 07-13-2005 · Stop Date: 10-10-2005	Prescriber: Adams, Bradford	RX #: 250195222
Artificial tears x 180 d PRN Adm. tears 30 m ā cosopt	L P	
Start Date: · Stop Date:	Prescriber:	RX #:
EC ASA 325mg ÷ po qd x 180 days	4a	→ (to day 25) · [illegible initials, days 27–29]
Start Date: 8/25/05 · Stop Date: 2/24/06	Prescriber: Darbouze	RX #:
Ditropan 5mg ÷ po bid x 180 days	4a 4p	→ (to day 25) · [illegible initials, days 27–31]
Start Date: 8/25/05 · Stop Date: 2/24/06	Prescriber: Darbouze/NP	RX #:
Mevacor 40mg ÷ po bid x 180 days	4a 4p	→ (to day 25) · [illegible initials, days 26–31]
Start Date: 8/25/05 · Stop Date: 2/24/06	Prescriber: Darbouze/NP	RX #:

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial
	[signature]	[initial]	[signature]	[initial]
Allergies:			[signature]	SW
Housing Unit: Population				
Patient ID Number: 238498				
Patient Name:				

Cammon, Lonnie ITA

Date of Birth [redacted]

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9 No Show
10 Other

Facility Name:

Month/Year Charting:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Tylenol 1g po bid PRN x 90 days	4a	→																								→	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	4p	→																								→	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

Start Date: 8/25/05 Prescriber: Darbouze

Stop Date: 11/25/05 RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date: Prescriber:

Stop Date: RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Start Date Prescriber:

Stop Date RX #:

Diagnosis

Allergies NKA

Housing Unit:

Patient ID Number: 238498

Patient Name: Cammon Lonnie II

Nurse's Signature	Initial	Nurse's Signature	Initial
[illegible]		[illegible]	[illegible]
		[illegible]	[illegible]

Date of Birth: [redacted]

Documentation Codes
1 Discontinued Order
2 Refused
3 Patient out of facility
4 Charted in Error
5 Lock Down
6 Self Administered
7 Medication out of Stock
8 Medication Held
9 No Show
10 Other

MEDICATION ADMINISTR... ...N RECORD

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Cosopt ÷ gtt OD/OS Bid x 180 days 6/24/05 — 12/24/05	0900 A																												
	1600 P																												

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 7/1/05 THROUGH 7/31/05

Physician Dr Bradford | Telephone No | Medical Record 23844

Alt Physician | Alt Telephone

lergies NKDA | Rehabilitative Potential

Diagnosis

Medicaid Number | Medicare Number | Complete Entries Checked: By: Bonnie J Lamb Title: LPN Date: 6/a

PATIENT Cammon, Lonnie | PATIENT CODE | ROOM NO | BED | FAC K

MEDICATION ADMINISTRATION RECORD

07/01/2005 (KIL-445) KILBY CORRECTIONAL FAC

STDT01

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
COSOPT OCUMETER PLUS (10ML) 2%/0 5% DROP INSTILL DROPS AS DIRECTED IN EACH EYE TWICE DAILY **NON-FORMULARY APPROVED UNTIL 07/06/05	
RX: 7216504 ROBBINS, M.D. (MED D, MICHAEL , START - 04/08/2005 STOP - 07/06/2005	
ACID-GONE (GENATON) 80MG/20MG TAB TAKE 2 TABLET(S) BY MOUTH TWICE DAILY AS NEEDED RX: 7308385 ADAMS, N.P., BRADFORD , NP START - 04/27/2005 STOP - 07/25/2005	
ACETAMINOPHEN (TYLENOL) 325MG TAB TAKE 2 TABLET(S) BY MOUTH TWICE DAILY AS NEEDED RX: 7308387 ADAMS, N.P., BRADFORD , NP START - 04/27/2005 STOP - 07/25/2005	
Ditropan 5mg PO BID x 90d 7/11/05 10/11/05	0900 1800
Benadryl 50mg PO BID PRN x 10d 7/15/05 7/24/05	
MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 07/01/2005 THROUGH 07/31/2005

Physician ADAMS, N.P., BRADFORD | Telephone No. | Medical Recor

Alt. Physician | Alt. Telephone

gies NO KNOWN DRUG ALLERGY | Rehabilitative Potential

Diagnosis

Medicaid Number | Medicare Number | Complete Entries Checked: By: Title: Date: 6

PATIENT CAMPBELL, LONNIE | PATIENT CODE 230400 | ROOM NO 1 | BED | FA

MEDICATION ADMINISTR..ION RECORD

06/01/2005

(KIL-445) KILBY CORRECTIONAL FAC

STDT01

MEDICATIONS | HOUR | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

OXYBUTYNIN (DITROPAN) 5MG TAB
TAKE 1 TABLET(S) BY MOUTH TWICE DAILY 0900 1800
RX: 7167258 WEBB, N P , MARTY , NP
START - 03/28/2005 STOP - 06/28/2005

COSOPT OCUMETER PLUS (10ML) 22/0.5% DROP K O P
INSTILL DROPS AS DIRECTED IN EACH EYE TWICE DAILY **NON-FORMULARY APPROVED UNTIL 07/06/05
4/04/05 - 7/04/05
P/O 5/13/05

RX: 7216504 ROBBINS, M.D. (MED D, MICHAEL ,
START - 04/08/2005 STOP - 07/06/2005

ACID-GONE (GENATON) 60MG/20MG TAB P R N
TAKE 2 TABLET(S) BY MOUTH TWICE DAILY AS NEEDED
RX: 7308385 ADAMS, N.P., BRADFORD , NP
START - 04/27/2005 STOP - 07/25/2005

ACETAMINOPHEN (TYLENOL) 325MG TAB P R N
TAKE 2 TABLET(S) BY MOUTH TWICE DAILY AS NEEDED
RX: 7308387 ADAMS, N.P., BRADFORD , NP
START - 04/27/2005 STOP - 07/25/2005

Zantac 150mg po b.i.d.

Elimite (or equiv.) K O P
To entire body below neck
Warm Shower. Leave on 8o. Shower off in A.M.
6-16-05

Benadryl 50mg P R N
Bid PRN x 10d
6-16-05 6/27/05

MEDICATIONS | HOUR | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 06/01/2005 THROUGH 06/30/2005

Physician ADAMS, N.P , BRADFORD | Telephone No | Medical Record N

Alt. Physician | Alt. Telephone

...rgies NO KNOWN DRUG ALLERGY | Rehabilitative Potential

Diagnosis

Medicaid Number | Medicare Number | Complete Entries Checked: By: | Title: RN | Date: 5/2

PATIENT

CANNON, LONNIE

PATIENT CODE 238498 | ROOM NO 1 | BED | FACIL

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1-28
Cosopt ī gtt OD/OS Bid x 180 days 6/1/05 – 6/30/05	0900 1600	BR, BR, DD, BR, BR, AW, BR, BR, BR, BR ... See Below
Cosopt ī gtt OD/OS Bid X 180 days 6-24-05 → 12-24-05	0900 1600	→ BR → AW

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 6/1/05 THROUGH 6/30/05

Physician: Dr Bradford

Alt. Physician

Telephone No

Alt. Telephone

Medical Record 238498

Allergies NKDA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked: By: Bernice Starks Title: LPN Date: 5/

PATIENT Cammon Lonnie

PATIENT CODE

ROOM NO

BED

FAC K

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
Ditropan 5mg BIDX90D 3/28 -6/28/05	0900 1800	
Cosopt 2x day OD 4/4-7/4/05	KCP	
AFC 94-6wk 4/8 - 5/2/05	KCP	
Antacid 1T BID PRN X90D 4/25-7/25/05	PRN	
Tylenol 650mg BIDX PRN X90 4/25-7/25/05	PRN	
Zantac 150mg BIDX 30 4/25-5/24/05	0900 1800	

MEDICATIONS	HOUR	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 5/1/05 THROUGH 5/31/05

Physician

Alt Physician Dr Robbins

Telephone No

Alt. Telephone

Medical Record 238

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked By: Katie Bailey RN Title 4/21/05 Date

PATIENT Cammeron Lonnie

PATIENT CODE ROOM NO BED FAC

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Cosopt 1 gtt OD/OS BID x 180 5/15/05 11/15/05	09																												
	1800																												

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 5/1/05 THROUGH 5/31/05

Physician Dr Bradford

Telephone No.

Medical Record

Alt. Physician

Alt. Telephone

Allergies NKDA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By:

Title:

Date:

PATIENT

PATIENT CODE

ROOM NO

BED

MEDICATION ADMINISTRATION RECORD

#1

04/01/2005 (KIL-445) KILBY CORRECTIONAL FAC

STDT01

MEDICATIONS	HOUR	1–31
NAPROXEN (NAPROSYN) 250MG TAB TAKE 1 TABLET(S) BY MOUTH TWICE DAILY AS NEEDED RX: 7117669 WEBB, N.P., MARTY, NP START - 03/18/2005 STOP - 04/16/2005	PRN	
Ditropan 5mg BID X90D 3/28 - 6/28/05	0900 1800	
AFC BID x 10d 3/28 - 4/7/05	KOP	See new order
Diamox Acetazolamide 250mg. i p.o. BID, #14 tablets 4/1/05 4/8/05	0900 1800	In med cart
Timolol 0.5% Opthalmic Sol. i gtt OS BID 4/1/05	0900 1800	Repeat to ww for gtt
Cosopt 2xdy OD 4/4 - 7/4/05	KOP	
Entex PSE i PO BID x 7d 4-7-05 4-14-05	0900 1800	
antifungal cream q 4-6 wks 4/8/05 — 5/2/05	KOP	
Zantac 150mg PO BID x 30d 4/25/05 5/26/05	0900 1800	

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 04/01/2005 THROUGH 04/30/2005

Physician WEBB, N.P., MARTY	Telephone No.	Medical Record
Alt. Physician	Alt. Telephone	
Allergies NO KNOWN DRUG ALLERGY	Rehabilitative Potential	
Diagnosis		
Medicaid Number	Medicare Number	Complete Entries Checked: By: Katie Bailey Title: LPN Date: 3/21
PATIENT	PATIENT CODE	ROOM NO / BED / FAC

MEDICATION ADMINISTRATION RECORD

#2

STDT01

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
Antacids ii PO BID PRN x 90d 4/25/05 7/25/05	P N
Tylenol 650mg PO BID PRN x 90d 4/25/05 7/25/05	P N

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 4-25-05 THROUGH 4-30-05

Physician	Telephone No.	Medical Record 2 38
Alt. Physician	Alt Telephone	
llergies	Rehabilitative Potential	
Diagnosis		
Medicaid Number	Medicare Number	Complete Entries Checked: By: Title: Date:

PATIENT Cammon, Lonnie | PATIENT CODE | ROOM NO | BED | FAC

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28
Bicillin 2.4 mu IM qWK x3 4/6/05 4/20/05	0800

MEDICATIONS HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 4-6-05 THROUGH 4-30-05

Physician

Alt. Physician BAdAms CRNP

Telephone No.

Alt. Telephone

Medical Record 2384

Allergies NKA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked: By: Jones, LPN Title: Date:

PATIENT Cammons, Lonnie

PATIENT CODE | ROOM NO | BED | FAC

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS | HOUR | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

Naprosyn 250mg PO BID prn x30d 3-17-05 → 4-17-05 — R N

AFC BID X10d KOP 3/28/05 4-8-05 — K P

Ditropan 5mg PO BID X 90d 3/28/05 6/28/05 — 0900 1800

MEDICATIONS | HOUR | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

NURSE'S ORDERS MEDICATION NOTES AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 3-17-05 THROUGH 3-31-06

Physician M Webb CRNP | Telephone No | Medical Record 9384

Alt. Physician | Alt. Telephone

gies NKDA | Rehabilitative Potential

Diagnosis

Medicaid Number | Medicare Number | Complete Entries Checked: By: | Title: | Date: 3-

PATIENT Cammon, Lonnie | PATIENT CODE | ROOM NO | BED K

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Cammon, Lonnie	**Inmate Number:**	238498CA
Service Authorized:	Office Visits: Op Opthamology Referral	**Effective Dates:**	05/09/2006
Effective:	Visits authorized for 60 days from effective date	**Visits Authorized:**	1
Responsible Facility:	Easterling Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	16107090	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS
- Payment will not be processed until we receive a clinical summary

June 22 2006 10am
J.A. Jones 281-6688

For Payment Please Submit Claims To:

Prison Health Services
P O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician: _____ Date _____ Time _____

Reviewed and Signed By
Medical Director: _____ Date _____ Time _____

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Please send this form. must be Complete and Legible. You must Type ...e Authorization Letter to the service provider a... ...e of the Appointment

DEMOGRAPHICS

Site Name & Number: EASTERLING 835	Patient Name: (Last, First,) Cannon, Lonnie	Date: (mm/dd/yy) 05.09.06
Site Phone # (334)397-3128	Alias: (Last, First,)	Date of Birth: (mm/dd/yy) [redacted]
Site Fax # (334)397-3128	Inmate # 238498	PHS Custody Date: (mm/dd/yy) 12.17.04
Will there be a charge? [X] Yes [ ] No / Sex [X] Male [ ] Female	SS Number 424-36-0128	Potential Release Date: (mm/dd/yy) 11.17.06

Responsible party: [x] PHS [ ] Auto Ins. [ ] Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) [ ] Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):_____

FAXED 05

CLINICAL DATA

Requesting Provider: [X] Physician [ ] NP, PA [ ] Dental

Dr. Daniel Murray

Facility Medical Director Signature and Date:

[ ] Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

[X] Office Visit (OV) [ ] X-ray (XR) [ ] Scheduled Admission (SA)
[ ] Outpatient Surgery (OS) [ ] Dialysis (DA)

[ ] Routine [ ] Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: [ ] Radiation therapy [ ] Chemotherapy
Number of Visits/Treatments: ____ [ ] Other:_____

Specialist referred to: Dr. J.A. Jones Ophthalmology Dr. Cannemore

Type of Consultation, Treatment, Procedure or Surgery: Evaluation - Glaucoma + cataracts

Diagnosis:
ICD-9 code:

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

[X] Pertinent Documents have been attached and faxed.

History of illness/injury/sypmtoms with Date of Onset: CATARACTS GLAUCOMA

Results of a complaint directed physical examination: ✓ VA 05

Previous treatment and response (including medications): Meds

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

[ ] Offsite Service Recommended and Authorized
[ ] Alternative Treatment Plan (explain here):
[ ] More Information Requested: (See Attached)
[ ] Resubmitted with requested information.

Date resubmitted: __/__/__

Regional Medical Director Signature, printed name and date required:

__/__/__ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

EYE EXAMINATION SHEET

Facility: Easterling Date of Request: 05-09-06

Subjective: per pt. request

Past History: CNA, Glaucoma OU, Cataract OS

CONSULTATION REPORT

		W/Glasses	W/O Glasses
Snelling:	OD		20/50
	OS		LP

VA ↓ OS per Resident

OPHTH & EXT:
Dilated Eye Exam
YES NO
(circle one)

Mydriatic solution 1 to 2 gts per eye

Optometrist Signature

Nurse Signature

New RX: OD

OS

Glaucoma: YES NO
(circle one)

IOP: 19/40 (20/95-0)
Details:

A) 1) CATARACTS
2) Glaucoma
3) Blind OS

Cataracts: YES NO OS > OD
(circle one)
Details:

Frame:
Size:
Color:
Seg Ht:

P) 1-3) Ref.
PANNIMAN
EVAL.

Optometrist Signature/Date

Last Name	First	Middle	DOB	R/S	AIS Number
Cammon	Lonnie		[redacted]	B/M	238498

E EXAMINATION SHEET

Eastern Date of Request: 2/7/6

tory: G/C OS > OD / CAT

CONSULTATION REPORT

		W/Glasses	W/O Glasses
aelling:	OD	20/50	
	OS	LP	

Blind D g/c

OPHTH & EXT:

Dilated Eye Exam YES NO (circle one) DFE 2 months ago

Mydriatic solution 1 to 2 gts per eye

Optometrist Signature

Nurse Signature

Glaucoma: YES (circle one)

IOP: 16 18 @ 1:30

Details:

New RX: OD

OS

HAZY CONICA OS

Cataracts: YES NO (circle one)

Details: 4 mos 6/4

Frame:
Size:
Color:
Seg Ht:

Mont 7/6

Optometrist Signature/Date 2/7/6

Last Name	First	Middle	DOB	R/S	AIS Number
Cammon	Lonnie				

UTILIZATI_N MANAGEMENT REFERRAL RE_ _W FORM

PHS

must be Complete and Legible. You must Type or

Please send this fo_ _ _ Authorization Letter to the service provider at t_ _ _f the Appointment

DEMOGRAPHICS

Site Name & Number: EASTERLING 835	Patient Name: (Last, First,) CAMMON LORENZO	Date: (mm/dd/yy) 01/03/06
Site Phone # (334) 397-3128	Alias: (Last, First,)	Date of Birth: (mm/dd/yy) [redacted]
Site Fax # (334)397-3128	Inmate # 221498	PHS Custody Date: (mm/dd/yy) 12/17/04
Will there be a charge? ☒ Yes ☐ No / Sex ☒ Male ☐ Female	SS Number [redacted]	Potential Release Date: (mm/dd/yy) 11/17/06

Responsible party: ☒ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☒ Physician ☐ NP, PA ☐ Dental

DARBOUZE, J. A.

Facility Medical Director Signature and Date: 1/3/06

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy
Number of Visits/Treatments: ______ ☐ Other:______

Specialist referred to: Optometry

Type of Consultation, Treatment, Procedure or Surgery:

Diagnosis: Cataract, Glaucoma.
ICD-9 code:

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed

History of illness/injury/sypmtoms with Date of Onset: 77 BM. Glaucoma - Cataracts

Results of a complaint directed physical examination: 20/40 OU.

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION: ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required: ___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #:

FAXED

05a - UM Referral review form xls

EXHIBIT A-3

Blumberg No. 5131

EYE EXAMINATION SHEET

TO: (Service Physician) Eye Clinic

FROM: (Requesting Ward, Med. Fac. Phys.) #840 - Kelly

Date of Request: 8/5/05

Reason For Request: (Complaints and Finding)

Glaucoma Fu Cataract

Past History

Old Rx

Signature

Type of Consult ☐ Emergency ☐ Routine

CONSULTATION REPORT

Subjective: OD OS

OU 20/40

OPHTH:

New Rx: OD OS

Seg. Ht.

Ext:

Date Dispensed & Initials:

Seg. Type:

IDP & Time:

Frame:
Size:
Color:

OPTOMETRIST'S SIGNATURE

Patients Last Name	First	Middle	Age	R/S	ID No.
Cannons,	Lonnie				23848

F-65 Rev. (1-95)

Form must be Complete and Legible You must Type or Print

Please send this form to authorization before the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Kilby # 840

Site Phone #: 334-215-6706

Site Fax #: 334-215-6698

Will there be a charge? ☑ Yes ☐ No

Sex: ☑ Male ☐ Female

Patient Name: (Last, First,) CAMMON, LONNIE

Alias: (Last, First,)

Inmate #: 238498

SS Number: ___-__-____

Date: (mm/dd/yy) 7/11/05

Date of Birth: (mm/dd/yy) [redacted]

PHS Custody Date: (mm/dd/yy) 3/16/05

Potential Release Date: (mm/dd/yy) 11/17/06

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Bradford

Facility Medical Director Signature and Date: Mike Robbins MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy ☐ Other:

Number of Visits/Treatments: ____

Specialist referred to: Optometrist

Type of Consultation, Treatment, Procedure or Surgery:

Diagnosis: CATARACTS/GLAUCOMA

ICD-9 code:

You must include copies of pertinent reports such as lab results, x ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed

History of illness/injury/sypmtoms with Date of Onset:

20/40 OU
cataracts
Glaucoma

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information

Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required: ___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	CPT code:	UR Auth #: AL704

05a - UM Referral review form

W-92

- ☐ Sanders M. Benkwith, M.D.
- ☐ Tom Lyle Mitchell, Jr., M.D.
- ☐ John L. Swan, M.D.
- ☐ In C. Shin, M.D.
- ☐ Michael B. Bradford, O.D.
- ☐ Fred B. Setzer, O.D.
- ☐ Timothy M. Meadows, O.D.
- ☐ Zelda
- ☐ Sturbridge
- ☐ Prattville
- ☐ Vision Exam & Eye-Health Screening
- ☐ Work In
- ☐ Post-Op Visit
- ☐ Int/Short Exam

KILBY

Name: Cammons, Lonnie Acct. # 238498 Date: 08/05/06 Age: ______ M F

CC/HPI

Glaucoma
F/U Month using COSOPT
(NEW) c/o

Eye Meds

Medical History & ROS from ______
reviewed: Changes ☐ Yes ☐ No

VA NEAR
OD
OS
C C

Current RX
OD
OS

AR
OD
OS

Adnexa/Eyelids: ☐ nl ______
Pupils: ☐ nl ______
Muscles: ☐ nl ______

T OD ______
OS
@ ______

Dilate with:
☐ N
☐ M
☐ C

MR OD CR OD
OS OS

SLE:
- LLLS&C ☐ nl
- Cornea ☐ nl
- AC ☐ nl
- Lens ☐ nl
- IOL/PC ☐ nl
- Iris ☐ nl

MILD DRY EYE

Fundus:
- Optic Nerve ☐ nl rims
- Macula ☐ nl
- Vessels ☐ nl
- Periphery ☐ nl

Impressions:
DRY EYE SYNDROME

Plan: ARTIFICIAL TEARS (KOA) x180d
→ DO NOT USE FOR 30 MIN ̄p COSOPT
(DO NOT INTERRUPT COSOPT TREATMENT)

☐ No Contraindications f[or] planned surgical procedure.
☐ Surgical RBA discusse[d]
☐ Over for Notes

Letter to: ______ Signature: [signature] 8/5/06 MD/OD

MEP 1[0]
Rev 8/[0]

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

RECEIVED JUL 18 2005

DEMOGRAPHICS

Site Name & Number: Kilby # 840

Site Phone #: 334-215-6706

Site Fax #: 334-215-6695

Will there be a charge? ☑ Yes ☐ No

Sex: ☑ Male ☐ Female

Patient Name: (Last, First,) Cannon, Lonnie

Alias: (Last, First,)

Inmate #: 238498

SS Number

Date: (mm/dd/yy) 7-11-05

Date of Birth: (mm/dd/yy) [redacted]

PHS Custody Date: (mm/dd/yy) 3-16-05

Potential Release Date: (mm/dd/yy) 11-17-06

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Bradford

Facility Medical Director Signature and Date:

Mike Robbins MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

(This starts the approval window for the "open authorization period")

History of Illness/Injury/symptoms with Date of Onset:

20/40 OU
Cataracts
Glaucoma

Results of a complaint directed physical examination:

W22

❑ Sanders M. Benkwith, M.D.
❑ Tom Lyle Mitchell, Jr., M.D.
❑ John L. Swan, M.D.
❑ In C. Shin, M.D.
❑ Michael B. Bradford, O.D.
❑ Fred B. Setzer, O.D.
❑ Timothy M. Meadows, O.D.
❑ Zelda
❑ Sturbridge
❑ Prattville
❑ Vision Exam & Eye-Health Screening
❑ Work In
❑ Post-Op Visit
❑ Int/Short Exam

Name: Cannon, Lonnie L KUBM Acct. #238498 Date: 6/24/05 Age: ____ M F

CC/HPI

DFE

Hx: BLIND OS (END STAGE GLA)
- ϕ SURG REC ON CONSULT
- ~~GLA~~ SUS OD
COSOPT 5:21 OD/OS

LASR 8PM

Eye Meds

Medical History & ROS from ____ reviewed: Changes ❑ Yes ❑ No

VA	NEAR
OD	
OS	
C	C

Current RX
OD
OS

AR
OD
OS

Adnexa/Eyelids: ❑ nl _____

Pupils: ❑ nl

OD 8 Dilate with:

06/06/2005 MON 9:11 FAX →→→ KILBY 023/029

06/06/2005 MON 9:54 FAX 031/052

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

RECEIVED JUN 06 2005

DEMOGRAPHICS

Site Name & Number: Kilby # 040

Patient Name: (Last, First) Cameron, Lonnie

Date: (mm/dd/yy) 6 / 03 / 05

Site Phone # 334-215-6706

Alias: (Last, First)

Date of Birth: (mm/dd/yy) [redacted]

Site Fax # 334-215-6698

Inmate # 238498

PHS Custody Date: (mm/dd/yy) 03 / 16 / 05

Will there be a sharps? ☐ Yes ☐ No

Sex ☐ Male ☐ Female

Soc Security # [redacted]

Potential Release Date: (mm/dd/yy) 11 / 17 / 06

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services)

CLINICAL DATA

Requesting Provider: ☐ Physician ☐ NP, PA ☐ Dental

Dr. Bradford

Facility Medical Director Signature and Date:

Mike Robbins MD

☐ Service needs to be in the "approved via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DI)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) 6 / 24 / 05

(This starts the approval window for the "open authorization period")

History of illness/injury/symptoms with Date of Onset:

DFE - Fall on June 2nd

Results of a complaint directed physical examination:

06/10/2005 THU 10:54 FAX →→→ KILBY 003/016

06/06/2005 MON 9:54 FAX 031/052

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

RECEIVED JUN 06 2005

DEMOGRAPHICS

Site Name & Number: Kilby # 340

Patient Name: (Last, First) Cannon, Lonnie

Date: (mm/dd/yy) 6, 03, 05

Site Phone #: 334-215-6706

Alias: (Last, First)

Date of Birth: (mm/dd/yy) [redacted]

Site Fax #: 334-215-6698

Inmate #: 238498

PHS Custody Date: (mm/dd/yy) 03, 16, 05

Will there be a charge? ☐ Yes ☐ No

Sex: ☑ Male ☐ Female

SSI Number: [redacted]

Potential Release Date: (mm/dd/yy) 11, 17, 06

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☐ Physician ☐ NP, PA ☐ Dental

Dr. Bradford.

Facility Medical Director Signature and Date:

Mike Robbins MD

☐ Service meets criteria "approval via protocol"

History of illness/injury/symptoms with Date of Onset:

DFE - Fall on June 24th

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DIA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) 6, 24, 05

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy

Results of a complaint directed physical examination:

W-22

EYE EXAMINATION SHEET

TO: (Service Physician) Eye Clinic

FROM: (Requesting Ward Med. Fac. Phys.) Cellry #840

Date of Request:

Reason For Request: (Complaints and Finding)

DFE | IOP

FU

COSOPT bid. ou/os

W57 1030 Am

Past History

Old Rx

Signature

Type of Consult ☐ Emergency ☐ Routine

CONSULTATION REPORT

Subjective: OD OS

OPHTH:

New Rx: OD

UTILIZATION M[illegible]AGEMENT REFERRAL REVI[illegible]W FORM

Form n[illegible] be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Kilby # 840

Site Phone #: 334-215-6706

Site Fax #: 334-215-6698

Patient Name: (Last, First,) [illegible]

Alias: (Last, First,)

Inmate # [illegible]

Date: (mm/dd/yy) 05/13/06

[illegible] Birth: (mm/dd/yy) [redacted]

PHS Custody Date: (mm/dd/yy) 03/10/05

Potential Release Date: (mm/dd/yy) 11/10/08

Will there be a charge? ☐ Yes ☐ No

Sex ☑ Male ☐ Female

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Bradford

Facility Medical Director Signature and Date:

Wm Rollins MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

History of illness/injury/sypmtoms with Date of Onset:

Results of a complaint directed physical examination:

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Cammon, Lonnie	**Inmate Number:**	238498CA
Service Authorized:	Office Visits: Outpatient Optometry Referral	**Effective Dates:**	05/13/2005 to 11/13/2005
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Kilby Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	15027206	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule") Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.

05/19/2005 THU 14:33 FAX →→→ Kilby 025/039

ADMIN 004

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: Kilby # 840

Site Phone #: 334-215-6706

Site Fax #: 334-215-6698

Patient Name: (Last, First) [redacted]

Alias: (Last, First)

Inmate #: [redacted]

SS Number: [redacted]

Date: (mm/dd/yy) [redacted]

PHS Custody Date: (mm/dd/yy) [redacted]

Potential Release Date: (mm/dd/yy) [redacted]

RECEIVED MAY 19 2005

Will there be a charge? ☐ Yes ☐ No

Sex: ☐ Male ☐ Female

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☐ Physician ☐ NP, PA ☐ Dental

Dr Bradford

Facility Medical Director Signature and Date:

Mike Robbins MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

History of illness/injury/symptoms with Date of Onset:

Results of a complaint directed physical examination:

W 22

EYE EXAMINATION SHEET

TO: (Service Physician) Eye Clinic

FROM: (Requesting Ward, Med. Fac. Phys.) Kilby #840

Date of Request: 4/4/05

Reason For Request: (Complaints and Finding)

~~[illegible]~~ Cataract Fu after UAB

SAW OR SCANNER @ UAB FOR OPT. WORKUP RECOMMENDED Cosopt 1 OD b.i.d

Past History

Old Rx

Signature

Type of Consult ☐ Emergency ☐ Routine

CONSULTATION REPORT

Subjective: OD OS Cosopt OD/OS THIS AM

OPHTH:

New Rx: OD

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

For[illegible]st be Complete and Legible You must Type or Print

Please send this form with[illegible] Authorization Letter to the service provider at the tim[illegible] the Appointment

DEMOGRAPHICS

Site Name & Number: Kilby #840	Patient Name: (Last, First,) Cannon, Lonnie	Date: (mm/dd/yy) 04.04.05
Site Phone # 334.215.6706	Alias: (Last, First,)	Date of Birth: (mm/dd/yy) [redacted]
Site Fax # 334.215.6698	Inmate # 238498	PHS Custody Date: (mm/dd/yy) 03.16.05
Will there be a charge? ☑ Yes ☐ No / Sex ☑ Male ☐ Female	SS Number [redacted]	Potential Release Date: (mm/dd/yy) 11.17.08

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):_____

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Bradford

Facility Medical Director Signature and Date:

Mike Tobias MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) 4/22/05

History of illness/injury/symptoms with Date of Onset:
Saw Dr. Bradford 4/1/05 and was referred to UAB Glaucoma Specialist. Saw Dr. Swanner at UAB on 4/4/05 and exam was done and orders received. Dr. Swanner ordered a follow up with Dr. Bradford for Cataract RT eye. Blind in left eye

Results of a complaint directed physical examination:
OD - Glaucoma Suspect
Cataract Present
OS - Blind

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Cammon, Lonnie	**Inmate Number:**	238498CA
Service Authorized:	Office Visits: Outpatient Optometry Referral	**Effective Dates:**	04/12/2005 to 10/12/2005
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Kilby Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	14897104	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary

For Payment Please Submit Claims To:

Prison Health Services
P.O Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.

ADMIN 006

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Kilby #840

Patient Name: (Last, First) Cammon, Lonnie

Date: (mm/dd/yy) 04.04.05

Site Phone # 334-215-6704

Alias: (Last, First)

Date of Birth: (mm/dd/yy) [redacted]

Site Fax # 334-215-6698

Inmate # 238498

PHS Custody Date: (mm/dd/yy) 03.16.05

Will there be a charge? ☑ Yes ☐ No

Sex ☑ Male ☐ Female

SS Number [redacted]

Potential Release Date: (mm/dd/yy) 11.17.08

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Bradford

Facility Medical Director Signature and Date:

Mike Robbs MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) 4.22.05

(This starts the approval window [illegible]

History of illness/injury/symptoms with Date of Onset:
Saw Dr. Bradford 4/1/05 and was referred to UAB Glaucoma Specialist. Saw Dr. Swanner at UAB on 4/4/05 and exam was done and orders received. Dr. Swanner ordered a follow up with Dr. Bradford for Cataract RT eye. Blind in left eye

Results of a complaint directed physical examination:
OD – Glaucoma Suspect
Cataract Present
OS – Blind

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

RECEIVED APR 01 2005

DEMOGRAPHICS

Site Name & Number:	Patient Name: (Last, First,)	Date: (mm/dd/yy)
Kilby # 840	Cammon, Lonnie	04 / 01 / 05
Site Phone #	**Alias: (Last, First,)**	**Date of Birth: (mm/dd/yy)**
334-215-6706		[redacted]
Site Fax #	**Inmate #**	**PHS Custody Date: (mm/dd/yy)**
334-215-6698	238498	3 / 16 / 05
Will there be a charge? ☐ Yes ☐ No / **Sex** ☑ Male ☐ Female	**SS Number**	**Potential Release Date: (mm/dd/yy)** 11 / 17 / 06

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Calahan Eye Foundation /Dr-Swanner

Facility Medical Director Signature and Date:

Nick Rollins MD

☐ Service meets criteria for "approval via protocol"

History of Illness/Injury/symptoms with Date of Onset:

Advanced Glaucoma 05

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☑ Urgent

Results of a complaint directed physical examination:

PRISON HEALT SERVICES: AUTHORIZATI I LETTER

Patient Name:	Cammon, Lonnie	**Inmate Number:**	238498CA
Service Authorized:	Office Visits: Op Opthamology Referral	**Effective Dates:**	04/04/2005
Effective:	Visits authorized for 60 days from effective date.	**Visits Authorized:**	1
Responsible Facility:	Kilby Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	14872978	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
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- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

4/5/05

The consulting physician should complete this section.

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number: Kilby # 840

Patient Name: (Last, First,) Cammon, Lonnie

Date: (mm/dd/yy) 04 / 01 / 05

Site Phone # 334-215-6706

Alias: (Last, First,)

Date of Birth: (mm/dd/yy) [redacted]

Site Fax # 334-215-6698

Inmate # 238498

PHS Custody Date: (mm/dd/yy) 3 / 16 / 05

SS Number

Potential Release Date: (mm/dd/yy) 11 / 17 / 06

Will there be a charge? ☐ Yes ☐ No

Sex ☑ Male ☐ Female

Responsible party: ☑ PHS ☐ Auto Ins. ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Callahan Eye Foundation /Dr-Swanner

Facility Medical Director Signature and Date:

Mike Robbins MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

History of illness/injury/sypmtoms with Date of Onset:

Advanced Glaucoma OS

Results of a complaint directed physical examination:

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

3/3

Form mu Complete and Legible You must Type or Print

Please send this form with the a orization Letter to the service provider at the time c a Appointment

PHS

DEMOGRAPHICS

Site Name & Number:	Patient Name: (Last, First,)	Date: (mm/dd/yy)
Kilby # 840	Cammon, Lonnie	03/17/05
Site Phone #	**Alias: (Last, First,)**	**Date of Birth: (mm/dd/yy)**
334-215-6706		[redacted]
Site Fax #	**Inmate #**	**PHS Custody Date: (mm/dd/yy)**
334-215-6698	238498	03/16/05
Will there be a charge? ☑ Yes ☐ No / **Sex** ☑ Male ☐ Female	**SS Number** ___-___-____	**Potential Release Date: (mm/dd/yy)** 11/17/06

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):_____

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Bradford

Facility Medical Director Signature and Date:

Mike Robbins MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ ~~Routine~~ ☐ Urgent

Estimated Date of Service (mm/dd/yy) / /

History of illness/injury/sypmtoms with Date of Onset:

Glaucoma OS

Results of a complaint directed physical examination:

OD 20/50 OD 20/70

OS 20/200 OS 20/70

PRISON HEALT SERVICES: AUTHORIZATIC LETTER

Patient Name:	Cammon, Lonnie	**Inmate Number:**	238498CA
Service Authorized:	Office Visits: Outpatient Optometry Referral	**Effective Dates:**	03/30/2005
Effective:	Visits authorized for 60 days from effective date	**Visits Authorized:**	1
Responsible Facility:	Kilby Correctional Facility	**Contact Name:**	Michelle Pope
Authorization Number:	14850472	**Telephone Number:**	(334)395-5973 Ext 14

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
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- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.

03/18/2005 FRI 13:31 FAX →→→ KILBY 020/020

03/18/2005 11:47 FAX 3342159126 ADMIN 001

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

FAXED RECEIVED MAR 18 2005

DEMOGRAPHICS

Site Name & Number: Kilby # 840

Patient Name: (Last, First) Cammon, Lonnie

Date: (mm/dd/yy) 03,17,05

Site Phone # 334-215-6706

Alias: (Last, First)

Date of Birth: (mm/dd/yy) [redacted]

Site Fax # 334-215-6698

Inmate # 238498

PHS Custody Date: (mm/dd/yy) 03,16,05

SS Number

Potential Release Date: (mm/dd/yy) 11,17,06

Will there be a charge? ☒ Yes ☐ No

Sex ☒ Male ☐ Female

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare, Medicaid and Veterans Administration Services):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Bradford

Facility Medical Director Signature and Date:

Mike Rolls MD

☐ Service meets criteria for "approval via protocol"

History of illness/injury/symptoms with Date of Onset:

Glaucoma OS

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) __/__/__

Results of a complaint directed physical examination:

OD 20/50 OD 20/70

OS 20/200 OS 20/70

Patient Name: CC	Cammon, Lonnie	**Inmate Number:**	238498CA
Service Authorized:	Office Visit: O/P Opthamology		
Responsible Facility:	Kilby Correctional Facility	**Contact Name:**	Michele Pope
Authorization Number:		**Telephone Number:**	(334) 395-____

Note to Provider of Services:

- **Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.**
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- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P O Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility

VF

	Rel		Progressed
	☐Y ☐N	☐ ☐N	☐Y ☐N
	☐Y ☐N	☐Y ☐N	☐Y ☐N

DFE

OD Neg Pos		OS Neg Pos	
☑ ☐	Vitreous	☑ ☐	
☑ ☐	Macula	☑ ☐	
☑ ☐	Vessels	☑ ☐	
☑ ☐	Periphery	☑ ☐	

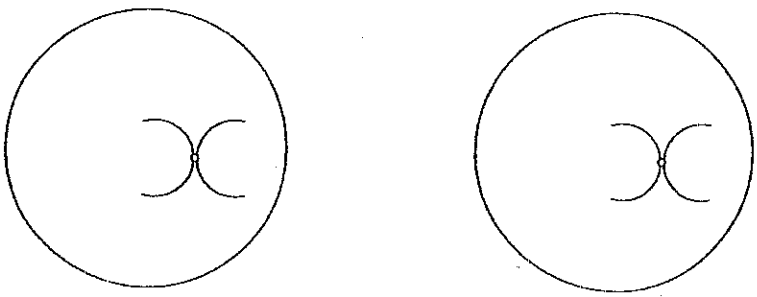
Meds

TXE = Timoptic XE 0/2
Bs = Betoptic S
X = Xalatan
Tr = Trusopt
Co = Cosopt
P = Pilocarpine
PF = Pred Forte
At = Atopine
Oc = Ocuflox

Diamox 250 mg

Retina:

OD



Orders
Refract
Color Plates
Dilate
SITA 24-2
SWAP 24-2
SITA Fast
FDT

☐ Sanders M. Benkwith, M.D.
☐ James R. Glassner, M.D.
☐ Tom Lyle Mitchell, Jr., M.D.
☐ John L. Swan, M.D.
☑ Michael B. Bradford, O.D.
☐ Fred B. Setzer, O.D.
☐ Timothy M. Meadows, O.D.
☐ Zelda
☐ Sturbridge
☐ Prattville
☐ Vision Exam & Eye-Health Screening
☐ Work In
☐ Post-Op Visit
☐ Int/Short Exam

KLB

Name: CANNON, LONNIE Acct # 238428 Date: 4/1/15 Age: 77 (M) F

CC/HPI NEW MAN

HISTORY OF CATARACTS/GLAUCOMA OS OD/OS

("USED DROPS IN (L) EYE AT HOME - NONE x 2-3 WKS")

Eye Meds

Sys. Meds

FH

	VA	NEAR
OD		
OS		

Current RX
OD
OS

AR
OD
OS

C C

Adnexa/Eyelids: ☐ nl

Pupils: ☐ nl

LabCorp Laboratory Corporation of America

Order Status: Final

Laboratory Corporation of America

ACCESSION #	ACCOUNT #
191-205-5796-0	01389085

PATIENT NAME
CAMMON,LONNIE

PATIENT ID #	D.O.B.	AGE	GENDER
238498	[redacted]	4	M

PATIENT PHONE #	CHART #
000-000-0000	

REFERRING PHYSICIAN
SIDDIQ I

LAB ORDER #	DRAWN
CD-41167604526	7/10/2006 12:28

RECEIVED	REPORTED
7/10/2006	7/11/2006 7:47

Bullock Correctional Facility
Prison Health Services
104 Bullock Dr.
Union Springs, AL 36089-5107

FASTING: N

TESTS ORDERED: CMP14+LP+5AC, CBC With Differential/Platelet

Result Name	Normal	Abnormal	Reference Range		Lab
CMP14+LP+5AC					
Chemistries					MB
Glucose, Serum	80		65 - 99	mg/dL	MB
Uric Acid, Serum	5.6		2.4 - 8.2	mg/dl	MB
BUN	15		5 - 26	mg/dL	MB
Creatinine, Serum	1.0		0.5 - 1.5	mg/dL	MB
BUN/Creatinine Ratio	15		8 - 27		
Sodium, Serum	140		135 - 148	mmol/L	MB
Potassium, Serum	4.1		3.5 - 5.5	mmol/L	MB
Chloride, Serum	107		96 - 109	mmol/L	MB
Carbon Dioxide, Total		17 L	20 - 32	mmol/L	MB
Calcium, Serum	9.8		8.5 - 10.6	mg/dL	MB
Phosphorus, Serum	3.9		2.5 - 4.5	mg/dL	MB
Protein, Total, Serum	7.2		6.0 - 8.5	g/dL	MB
Albumin, Serum	4.3		3.5 - 4.8	g/dL	MB
Globulin, Total	2.9		1.5 - 4.5	g/dl	
A/G Ratio	1.5		1.1 - 2.5		
Bilirubin, Total	0.5		0.1 - 1.2	mg/dL	MB
Alkaline Phosphatase, Serum	89		25 - 160	IU/L	MB
LDH	227		100 - 250	IU/L	MB
AST (SGOT)	22		0 - 40	IU/L	MB
ALT (SGPT)	15		0 - 55	IU/L	MB
GGT	16		0 - 65	IU/L	MB
Iron, Serum	137		40 - 155	ug/dl	MB
					MB
Lipids					MB
Cholesterol, Total	146		100 - 199	mg/dL	MB
Triglycerides	75		0 - 149	mg/dL	MB
HDL Cholesterol		33 L	40 - 59	mg/dL	MB
VLDL Cholesterol Cal	15		5 - 40	mg/dL	
LDL Cholesterol Calc	98		0 - 99	mg/dL	
T. Chol/HDL Ratio	4.4		0.0 - 5.0	ratio units	
Estimated CHD Risk	0.8		0.0 - 1.0	times avg.	

T. Chol/HDL Ratio
Men Women

CONTINUED

LabCorp
Laboratory Corporation of America

Laboratory Corporation of America

Order Status: Final

ACCESSION #	ACCOUNT #
191-205-5796-0	01389085

PATIENT NAME
CAMMON,LONNIE

PATIENT ID #	D.O.B.	AGE	GENDER
238498	[redacted]	8 / 4	M

PATIENT PHONE #	CHART #
000-000-0000	

REFERRING PHYSICIAN
SIDDIQ I

LAB ORDER #	DRAWN
CD- 41167604526	7/10/2006 12:28

RECEIVED	REPORTED
7/10/2006	7/11/2006 7:47

Bullock Correctional Facility
Prison Health Services
104 Bullock Dr.
Union Springs, AL 36089-5107

FASTING: N

TESTS ORDERED: CMP14+LP+5AC, CBC With Differential/Platelet

Result Name	Normal	Abnormal	Reference Range		Lab
1/2 Avg.Risk			3.4	3.3	
Avg.Risk			5.0	4.4	
2X Avg.Risk			9.6	7.1	
3X Avg.Risk			23.4	11.0	

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

CBC With Differential/Platelet

WBC	5.4	4.0 - 10.5	x10E3/uL	MB
RBC	4.63	4.10 - 5.60	x10E6/uL	MB
Hemoglobin	14.4	12.5 - 17.0	g/dL	MB
Hematocrit	43.3	36.0 - 50.0	%	MB
MCV	94	80 - 98	fL	MB
MCH	31.2	27.0 - 34.0	pg	MB
MCHC	33.4	32.0 - 36.0	g/dL	MB
RDW	14.4	11.7 - 15.0	%	MB
Platelets	202	140 - 415	x10E3/uL	MB
Neutrophils	46	40 - 74	%	MB
Lymphs	37	14 - 46	%	MB
Monocytes	10	4 - 13	%	MB
Eos	6	0 - 7	%	MB
Basos	1	0 - 3	%	MB
Neutrophils (Absolute)	2.5	1.8 - 7.8	x10E3/uL	MB
Lymphs (Absolute)	2.0	0.7 - 4.5	x10E3/uL	MB
Monocytes(Absolute)	0.5	0.1 - 1.0	x10E3/uL	MB
Eos (Absolute)	0.3	0.0 - 0.4	x10E3/uL	MB
Baso (Absolute)	0.1	0.0 - 0.2	x10E3/uL	MB

LAB: MB LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000

DIRECTOR: John Elgin N MD

END OF REPORT

AL [redacted] DEPARTMENT OF CORRECTIONS

7B05U
RSW 7-06

Name: Cammon Lonnie

State ID No.: 238498

DOB: [redacted]

Race: B/m Sex:

INSTITUTION: Easkling

RADIOLOGY SERVICES REQUEST AND REPORT

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
Dr Dabbouse	4-5-06				

HISTORY/DIAGNOSIS:

X-RAY REQUEST

	ABDOMEN/KUB		FINGERS		NAVICULAR VIEW		SOFT TISSUE STUDIES
	ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)		FOOT		ORBITS		STERNUM
	ANKLE		HAND		OS CALCIS (HEEL)		TEMPORO-MANDIBULAR JOINTS
	CERVICAL SPINE		HIP		PELVIS		THORACIC SPINE
X	CHEST PA / LATERAL		HUMERUS		RADIUS/ULNA		TIBIA/FIBULA
	COCCYX		KNEE		RIBS		TOES
	CONE DOWN SELLA TURCICA		LUMBAR SPINE		SACRO-ILLIAC JOINTS		WRIST
	ELBOW		MANDIBLE		SCAPULA		ZYGOMA
	FACIAL BONES		MAXILLA		SHOULDER		ZYGOMATIC ARCH
	FEMUR		NASAL BONES		SKULL		

REPORT

Cammon

PA Chest: The heart is not enlarged. The lungs are clear.
IMPRESSION: THERE IS NO EVIDENCE OF ACTIVE CARDIOPULMONARY DISEASE.

D & T: 04-12-06 Howard P. Schiele, M.D./rr Board Certified Radiologist (Signature on file)

4/12/06

X-RAY TECHNOLOGIST'S NAME (PRINT)	X-RAY TECHNOLOGIST'S SIGNATURE	DATE, TIME EXAM PERFORMED
	K. Grant RXT	4-11-06
RADIOLOGIST'S NAME (PRINT)	RADIOLOGIST'S SIGNATURE	DATE SIGNED

LabCorp

Specimen #	Type	Primary Lab		
[illegible]	[illegible]	MB	[illegible]	[illegible]

Additional Information

ID- 9165398274

Clinical Information: [illegible] 0270728

Patient Name	Sex	Age (Yr/Mos)
AMMON, LONNIE	M	078/00

Patient Address

Physician ID	Patient ID
DARBOUZE	238498

Account: ~~Easterling Corr. Facility 01408055~~
Prison Health Services
200 Wallace Dr. 01
Clio AL 36017-0010
334-397-4471
PROV:

Date Collected	Date Entered	Date Reported	
03/13/06	03/13/06	03/14/06	6429

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
MP14+CBC/D/Plt					
Chemistries					MB
Glucose, Serum	129	High	mg/dL	65 - 99	MB
BUN	29	High	mg/dL	5 - 26	MB
Creatinine, Serum	1.2		mg/dL	0.5 - 1.5	MB
BUN/Creatinine Ratio	24			8 - 27	
Sodium, Serum	138		mmol/L	135 - 148	MB
Potassium, Serum	4.7		mmol/L	3.5 - 5.5	MB
Chloride, Serum	98		mmol/L	96 - 109	MB
Carbon Dioxide, Total	23		mmol/L	20 - 32	MB
Calcium, Serum	10.2		mg/dL	8.5 - 10.6	MB
Protein, Total, Serum	7.4		g/dL	6.0 - 8.5	MB
Albumin, Serum	4.1		g/dL	3.5 - 4.8	MB
Globulin, Total	3.3		g/dL	1.5 - 4.5	
A/G Ratio	1.2			1.1 - 2.5	
Bilirubin, Total	0.5		mg/dL	0.1 - 1.2	MB
Alkaline Phosphatase, Serum	72		IU/L	25 - 160	MB
AST (SGOT)	15		IU/L	0 - 40	MB
ALT (SGPT)	13		IU/L	0 - 55	MB
					MB
CBC, Platelet Ct, and Diff					MB
White Blood Cell (WBC) Count	9.2		x10E3/uL	4.0 - 10.5	MB
Red Blood Cell (RBC) Count	4.65		x10E6/uL	4.10 - 5.60	MB
Hemoglobin	14.6		g/dL	12.5 - 17.0	MB
Hematocrit	44.0		%	36.0 - 50.0	MB
MCV	95		fL	80 - 98	MB
MCH	31.4		pg	27.0 - 34.0	MB
MCHC	33.2		g/dL	32.0 - 36.0	MB
RDW	14.7		%	11.7 - 15.0	MB
Platelets	258		x10E3/uL	140 - 415	MB
Neutrophils	86	High	%	40 - 74	MB
Lymphs	11	Low	%	14 - 46	MB
Monocytes	3	Low	%	4 - 13	MB
Eos	0		%	0 - 7	MB
Basos	0		%	0 - 3	MB
Neutrophils (Absolute)	7.9	High	x10E3/uL	1.8 - 7.8	MB
Lymphs (Absolute)	1.0		x10E3/uL	0.7 - 4.5	MB
Monocytes(Absolute)	0.3		x10E3/uL	0.1 - 1.0	MB
Eos (Absolute)	0.0		x10E3/uL	0.0 - 0.4	MB
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	MB

Lab: MB LabCorp Birmingham Director: John Elgin, MD
1801 First Avenue South, Birmingham, AL 35233
For inquires, the physician may contact: Branch: 334-792-0902 Lab: 205-581-3500

LAST PAGE OF REPORT

3/17/06

FINAL REPORT

AMMON, LONNIE 238498 078-397-0173-0 Seq# 6429 03-14-06 08:28ET

AL DEPARTMENT OF CORRECTIONS

RADIOLOGY SERVICES REQUEST AND REPORT

TB 060 (N)

Name: Cammon Lonnie

State ID No: 228498

DOB: [redacted]

INSTITUTION: Easterling

Race: B/M Sex:

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP	Date of request	Time of request	Routine	Priority	Transportation or special needs
D. Darbouze	2-27-06				

HISTORY/DIAGNOSIS:

Swollen (L) arm

X-RAY REQUEST

	ABDOMEN/KUB		FINGERS		NAVICULAR VIEW		SOFT TISSUE STUDIES
	ACROMIO-CLAVICULAR JOINTS (W/W/O WEIGHT)		FOOT		ORBITS		STERNUM
	ANKLE		HAND		OS CALCIS (HEEL)		TEMPORO-MANDIBULAR JOINTS
X	CERVICAL SPINE Series		HIP		PELVIS		THORACIC SPINE
	CHEST PA / LATERAL		HUMERUS		RADIUS/ULNA		TIBIA/FIBULA
	COCCYX		KNEE		RIBS		TOES
	CONE DOWN SELLA TURCICA		LUMBAR SPINE		SACRO-ILLIAC JOINTS	X	WRIST (L)
X	ELBOW (L)		MANDIBLE		SCAPULA		ZYGOMA
	FACIAL BONES		MAXILLA	X	SHOULDER (L)		ZYGOMATIC ARCH
	FEMUR		NASAL BONES		SKULL		

Cammon

REPORT

CERVICAL SPINE: AP and lateral views show the vertebrae are well aligned. There are very severe degenerative and hypertrophic changes involving all intervertebral disc spaces from C3-C7. There is osteopenia. C7 is partially obscured and cannot be evaluated.
IMPRESSION: SEVERE CHRONIC CHANGES AS DESCRIBED. PLEASE SEE ABOVE COMMENTS.

LEFT SHOULDER: The examination shows no evidence of recent fracture or other significant bony abnormality.
IMPRESSION: NEGATIVE STUDY

Comment: Films are overpenetrated which limits the evaluation.

LEFT ELBOW, AP AND LATERAL VIEWS: There is soft tissue swelling overlying the elbow. There is a spur from the olecranon process. There are no other significant findings.

LEFT WRIST, AP AND LATERAL VIEWS: The examination shows no evidence of recent fracture or other significant bony abnormality.
IMPRESSION: NO BONY ABNORMALITY IS DETECTED. HOWEVER, IF SYMPTOMS PERSIST A FOLLOW UP EXAMINATION IS RECOMMENDED.

D: & T: 03-01-06 Howard P. Schiele, M.D./jhi Board Certified Radiologist (Signature on file)

3/3

X-RAY TECHNOLOGIST'S NAME (PRINT)	X-RAY TECHNOLOGIST'S SIGNATURE	DATE, TIME EXAM PERFORMED
	K. Grant RT(R)	2-28-06

RADIOLOGIST'S NAME (PRINT)	RADIOLOGIST'S SIGNATURE	DATE SIGNED

(WED)MAR 1 2006 15:01/ST 12:59/NO 6312281091 P 4

cammon, lonnie
ID: 238498

02/05/2006 10:01:26

D.O.B [redacted] 77 YEARS
Meds:
Class:
Dr:
Tech:

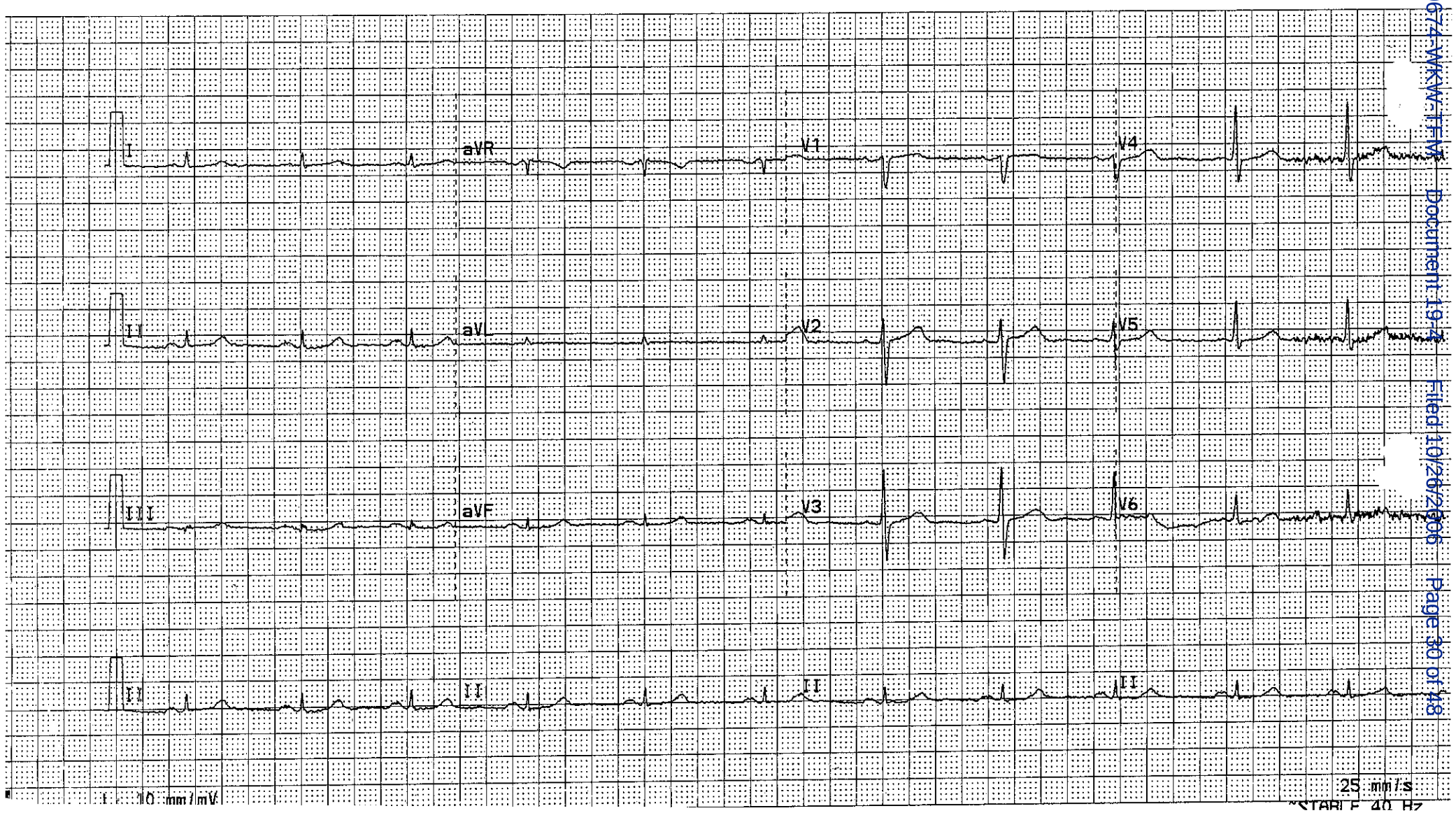
Vent. Rate:	67 bpm
RR Interval:	883 ms
PR Interval:	138 ms
QRS Duration:	84 ms
QT Interval:	386 ms
QTc Interval:	398 ms
QT Dispersion:	56 ms
P-R-T AXIS:	68° 39° 61°

SINUS RHYTHM
*** INTERPRETATION MADE WITHOUT KNOWING PATIENT'S GENDER ***
LOW QRS VOLTAGES IN STANDARD LIMB LEADS

Summary: BORDERLINE ECG

* Unconfirmed Analysis *

2/7/06



Cammon,Lonnie
ID: 238498

02/07/2006 14:18:16

SINUS RHYTHM
LOW QRS VOLTAGES IN STANDARD LIMB LEADS

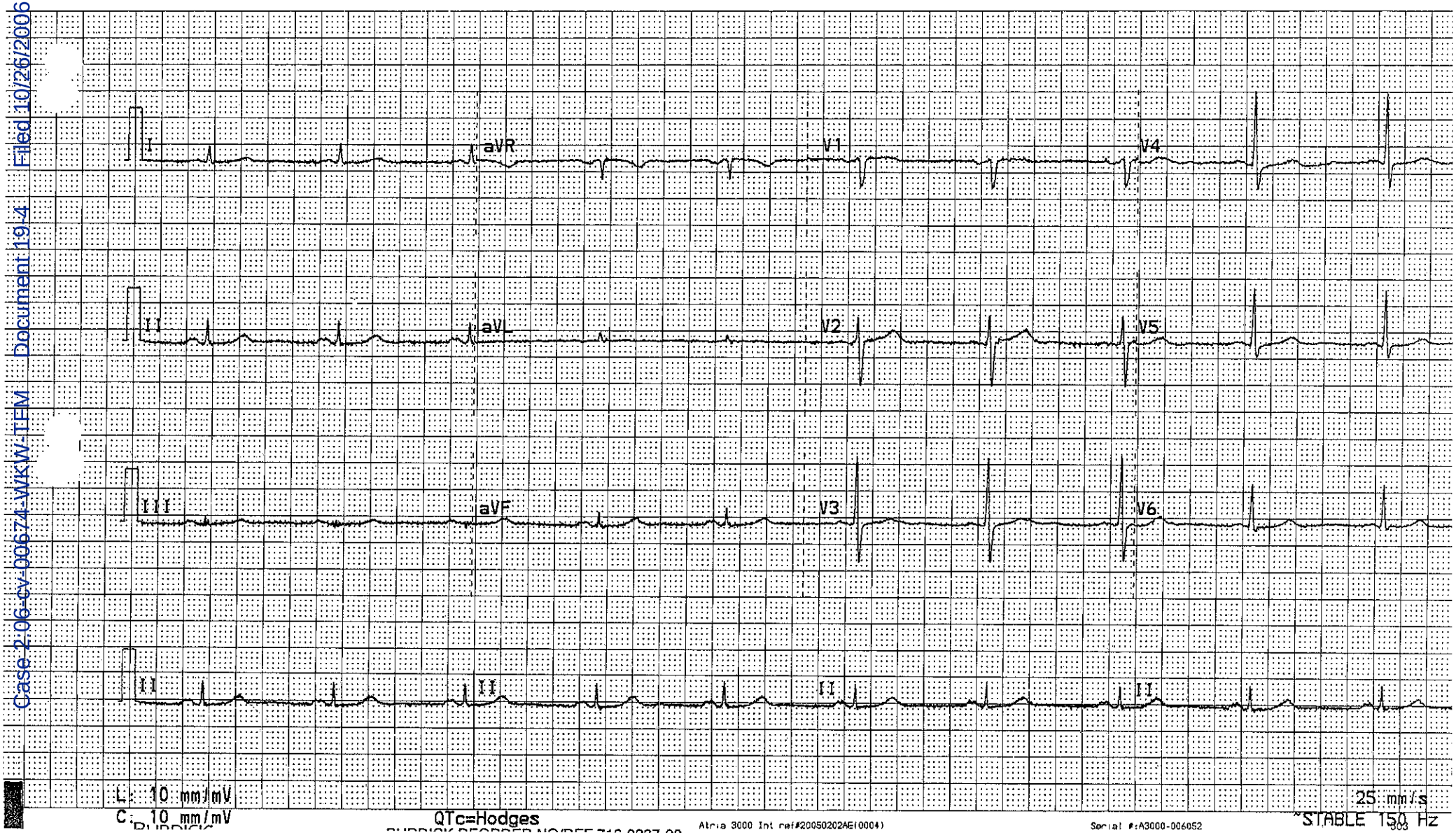
Summary: BORDERLINE ECG

* Unconfirmed Analysis *

D.O.B.: [redacted]	77 YEARS
MALE	OTHER RACE
Meds:	
Class:	
Dr:	Darbouzw
Tech:	SMcKinon

Vent. Rate:	60 bpm
RR Interval:	989 ms
PR Interval:	138 ms
QRS Duration:	78 ms
QT Interval:	402 ms
QTc Interval:	402 ms
QT Dispersion:	58 ms
P-R-T AXIS:	67° 33° 61°

2/7/06



cammon,lonnie
ID: 238498

01/24/2006 12:17:36

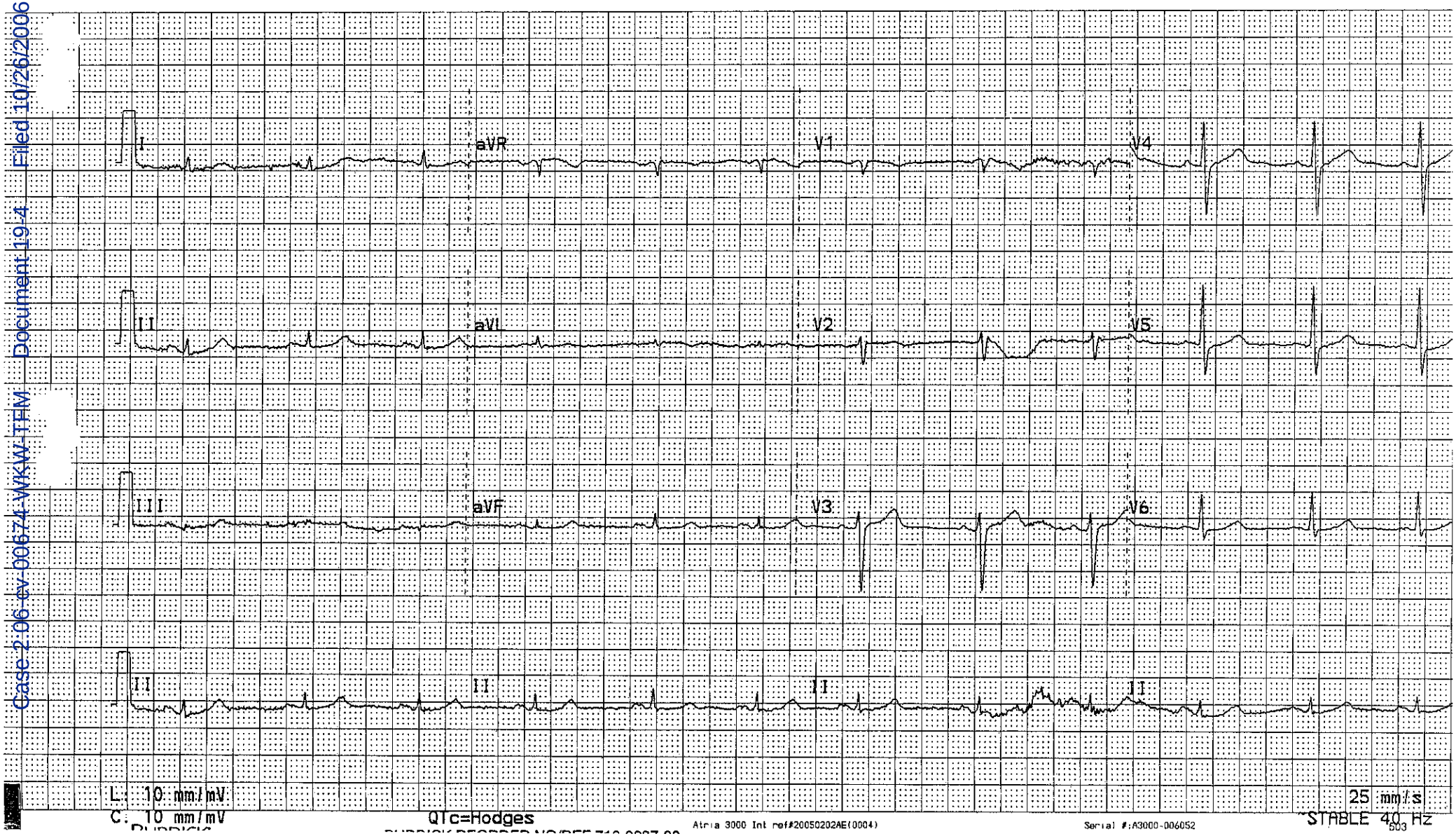
SINUS ARRHYTHMIA
LOW QRS VOLTAGES IN STANDARD LIMB LEADS

D.O.B.: [redacted] 77 YEARS
MALE
Meds:
Class:
Dr:
Tech:

Vent. Rate:	71 bpm
RR Interval:	844 ms
PR Interval:	132 ms
QRS Duration:	86 ms
QT Interval:	392 ms
QTc Interval:	411 ms
QT Dispersion:	64 ms
P-R-T AXIS:	64° 50° 63°

Summary: BORDERLINE ECG

* Unconfirmed Analysis *



Atria 3000 Int ref#20050202AE(0004)
Serial #:A3000-006052
503

01/24/2006 12:19:12

ID: #STAT#060124121912

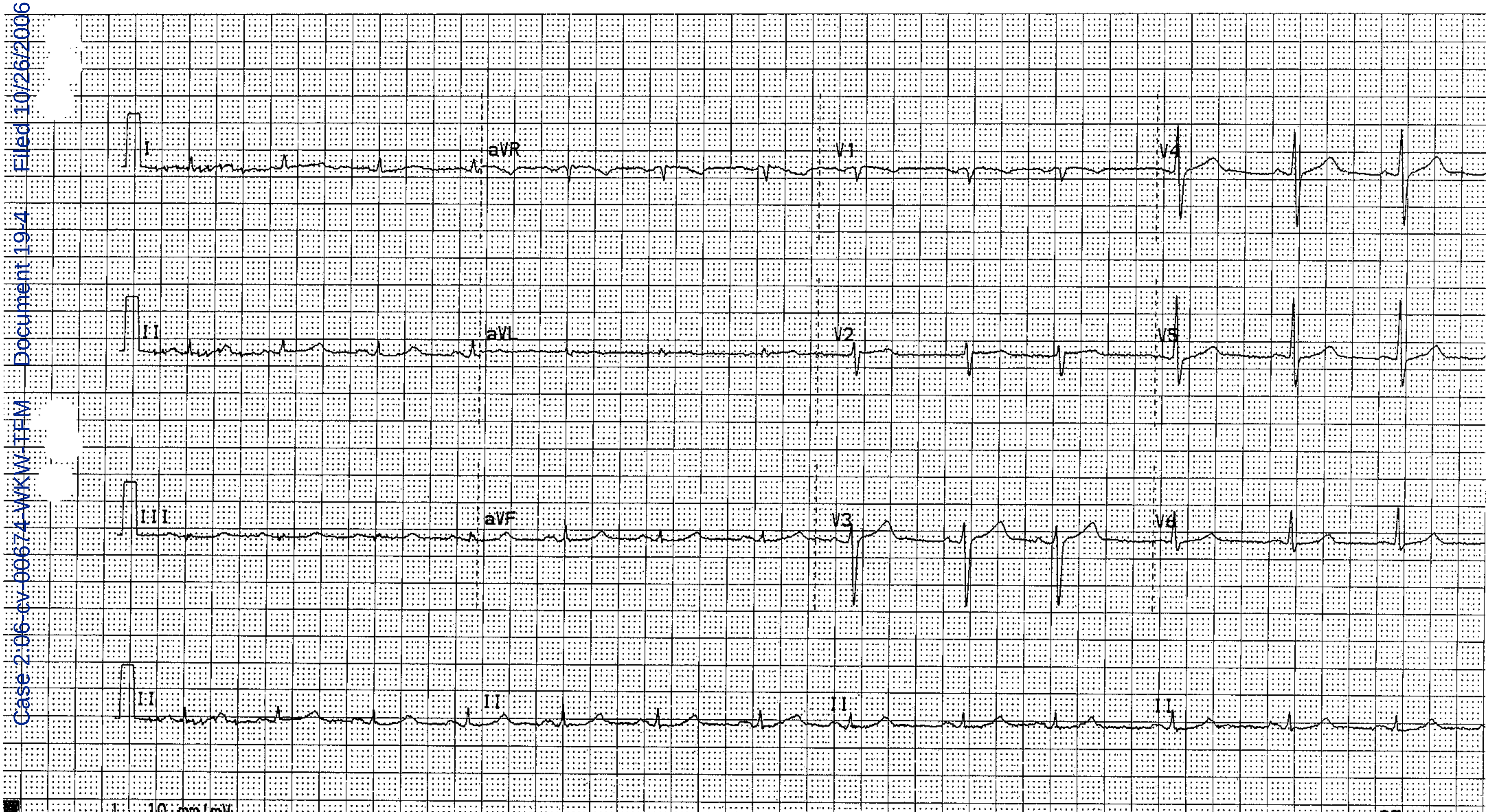
D.O.B.: [redacted]
Meds:
Class:
Dr:
Tech:

Vent. Rate:	80 bpm
RR Interval:	747 ms
PR Interval:	136 ms
QRS Duration:	82 ms
QT Interval:	380 ms
QTc Interval:	415 ms
QT Dispersion:	48 ms
P-R-T AXIS:	68° 53° 64°

SINUS ARRHYTHMIA
** INTERPRETATION MADE WITHOUT KNOWING PATIENT'S GENDER/AGE **
LOW QRS VOLTAGES IN STANDARD LIMB LEADS

Summary: BORDERLINE ECG * Unconfirmed Analysis *

1/24/06



L: 10 mm/mV
C: 10 mm/mV
BURDICK
QTc=Hodges
Atria 3000 Int ref#20050202AE(0004)
Serial #:A3000-006052
25 mm/s
~STABLE 40 Hz
903

cammon, lonnie
ID: 238498

01/19/2006 17:15:00

D.O.B.: [redacted] 77 YEARS
MALE
Meds:
Class:
Dr: darbouze
Tech: bowman

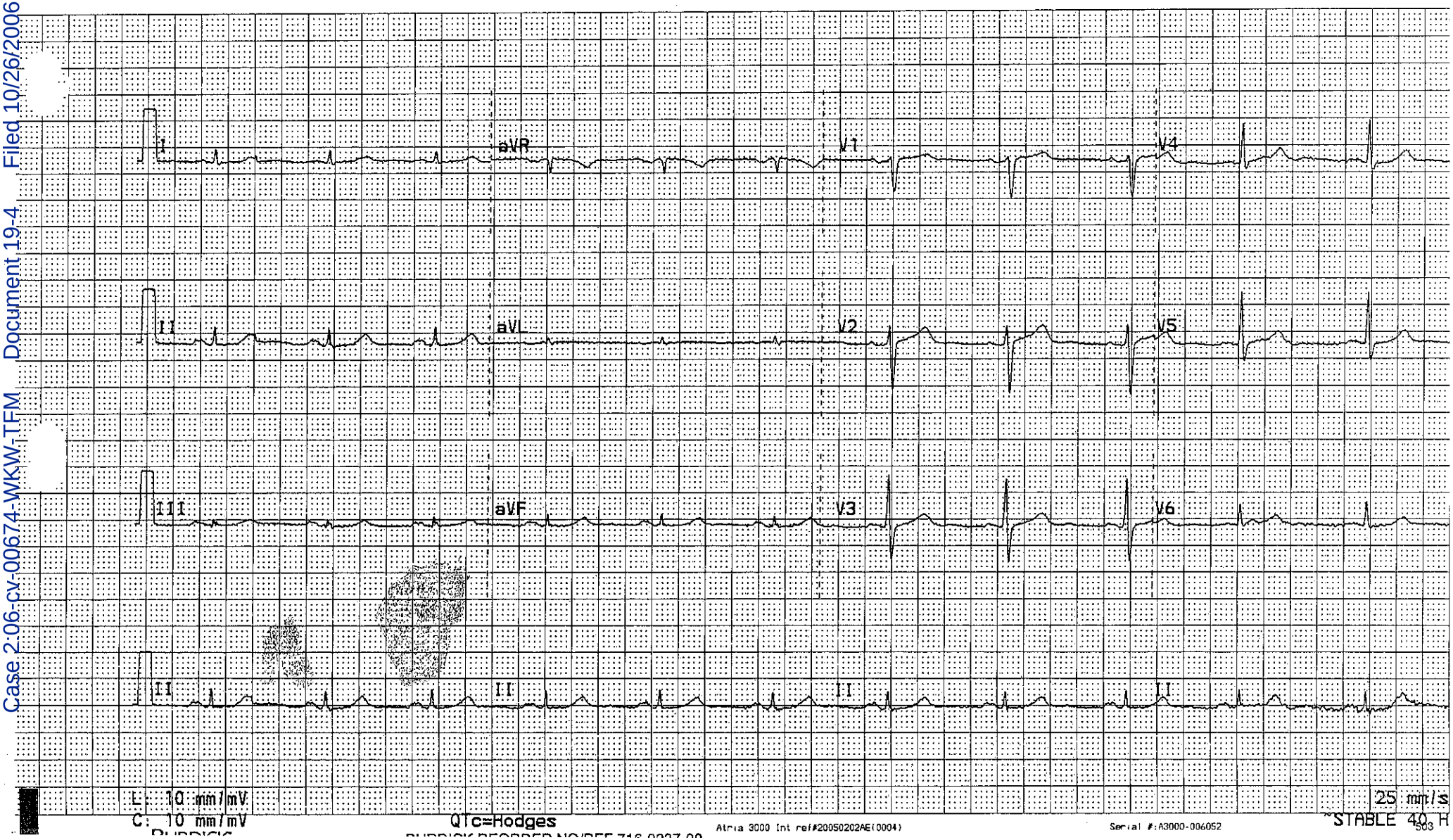
Vent. Rate:	69 bpm
RR Interval:	869 ms
PR Interval:	140 ms
QRS Duration:	80 ms
QT Interval:	390 ms
QTc Interval:	405 ms
QT Dispersion:	84 ms
P-R-T AXIS:	71° 52° 60°

SINUS RHYTHM
LOW QRS VOLTAGES IN STANDARD LIMB LEADS

Summary: BORDERLINE ECG

* Unconfirmed Analysis

1/27/06



Clanton Clinic 238448

ID: #STAT#051005183053

10/05/2005 18:30:52

B/P 138/94

D.O.B.: [redacted]
Meds:
Class:
Dr:
Tech:

Vent. Rate:	55 bpm
RR Interval:	1089 ms
PR Interval:	136 ms
QRS Duration:	80 ms
QT Interval:	410 ms
QTc Interval:	402 ms
QT Dispersion:	44 ms
P-R-T AXIS:	71° 44° 67°

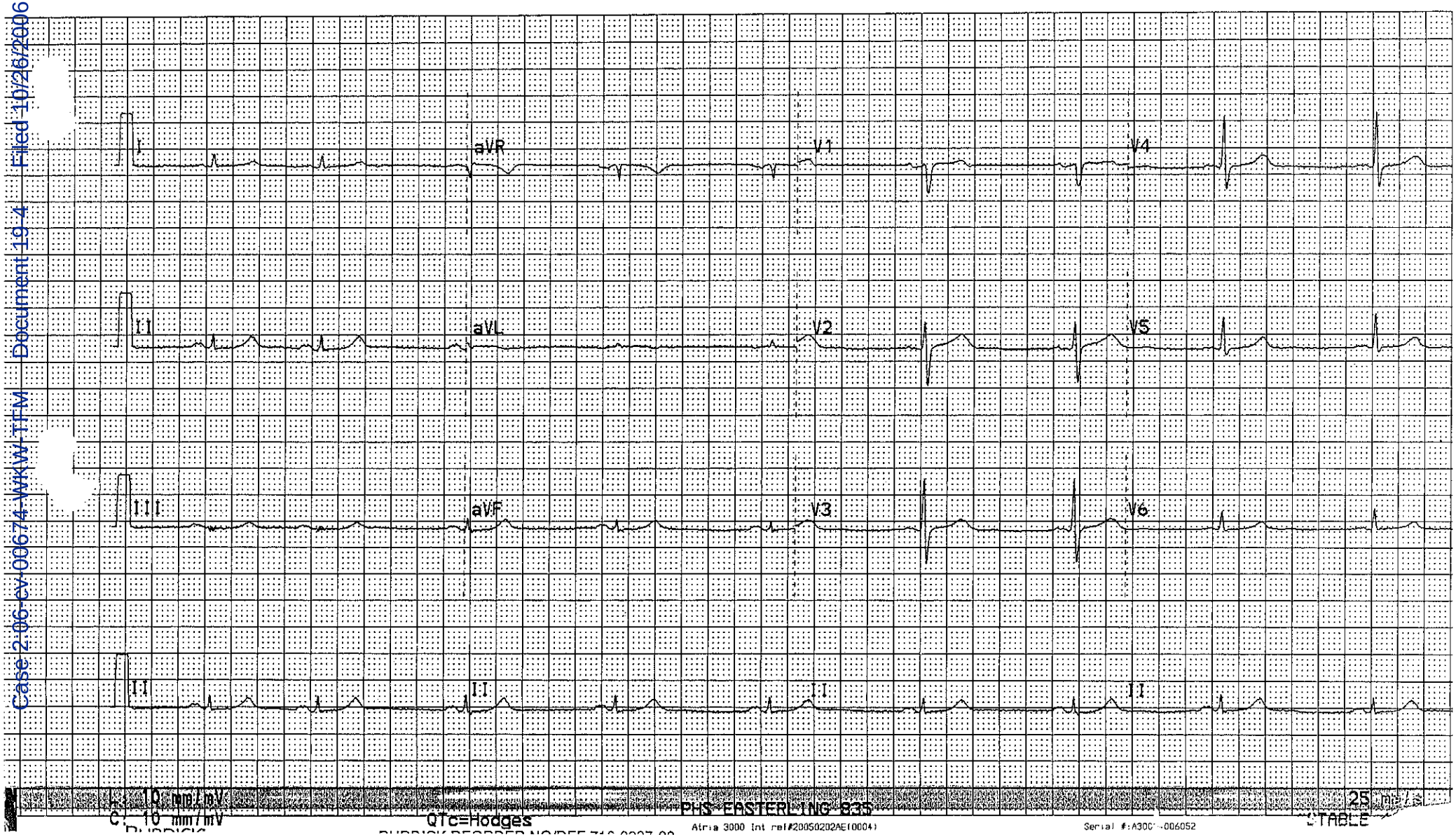
IRREGULAR SINUS BRADYCARDIA
** INTERPRETATION MADE WITHOUT KNOWING PATIENT'S GENDER/AGE **
LOW QRS VOLTAGES IN STANDARD LIMB LEADS

Summary: BORDERLINE ECG

* Unconfirmed Analysis *

FAXED

FAXED 10/5/05



KILBY CORRECTIONAL FA
PO BOX 11
MT. MEIGS, AL 36057

PATIENT NAME
Cammon, Lonnie

PRISON ID
238498

DATE SUBMITTED
3-17-05

NPY 3

TEST NAME	RESULT	REFERENCE RANGE	COMMENTS
HIV ANTIBODY	NR	NEGATIVE (NEG)	
RPR	R	NON-REACTIVE (NR)	
URINALYSIS	NEG		
APPEARANCE			
pH		pH 5- pH 6	
PROTEIN		NEGATIVE (NEG)	
GLUCOSE		NEGATIVE (NEG)	
KETONES		NEGATIVE (NEG)	
BILIRUBIN		NEGATIVE (NEG)	
BLOOD		< 5 RBC/MCL	
NITRITE		NEGATIVE (NEG)	
UROBILINOGEN		< 1.0 MG/DL	
LEUK. ESTERASE		NEGATIVE (NEG)	
SPECIFIC GRAVITY		1.016-1.022	

"A" These results are unreliable due to the age of the specimen.
"H" These results are unreliable due to the hemolyzed condition of the specimen.
"A+H" These results are unreliable due to the age and hemolyzed condition of the specimen.

CLIA ID NO. 01D0706289

WAYNE D. MERCER, PHD
LABORATORY DIRECTOR

E-6

DEPARTMENT OF CORRECTIONS

TREATMENT REQUEST AND RECORD

Date of Request	Requested By	Patient Status	Rx. Ordered
3-17-05	PE	☐ IP ☐ OP	

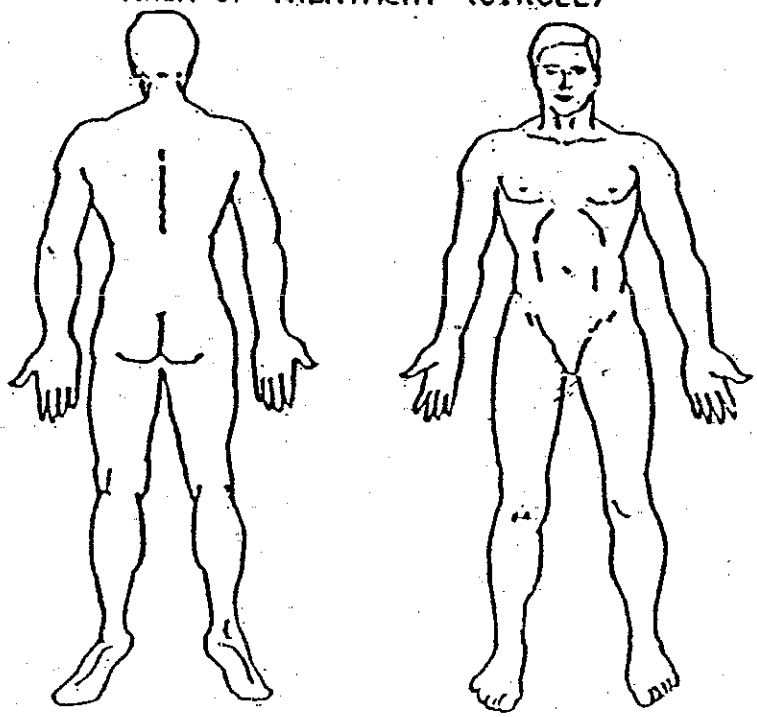
Clinical Diagnosis

EKG

Date of Order

Date of Surgery

AREA OF TREATMENT (CIRCLE)

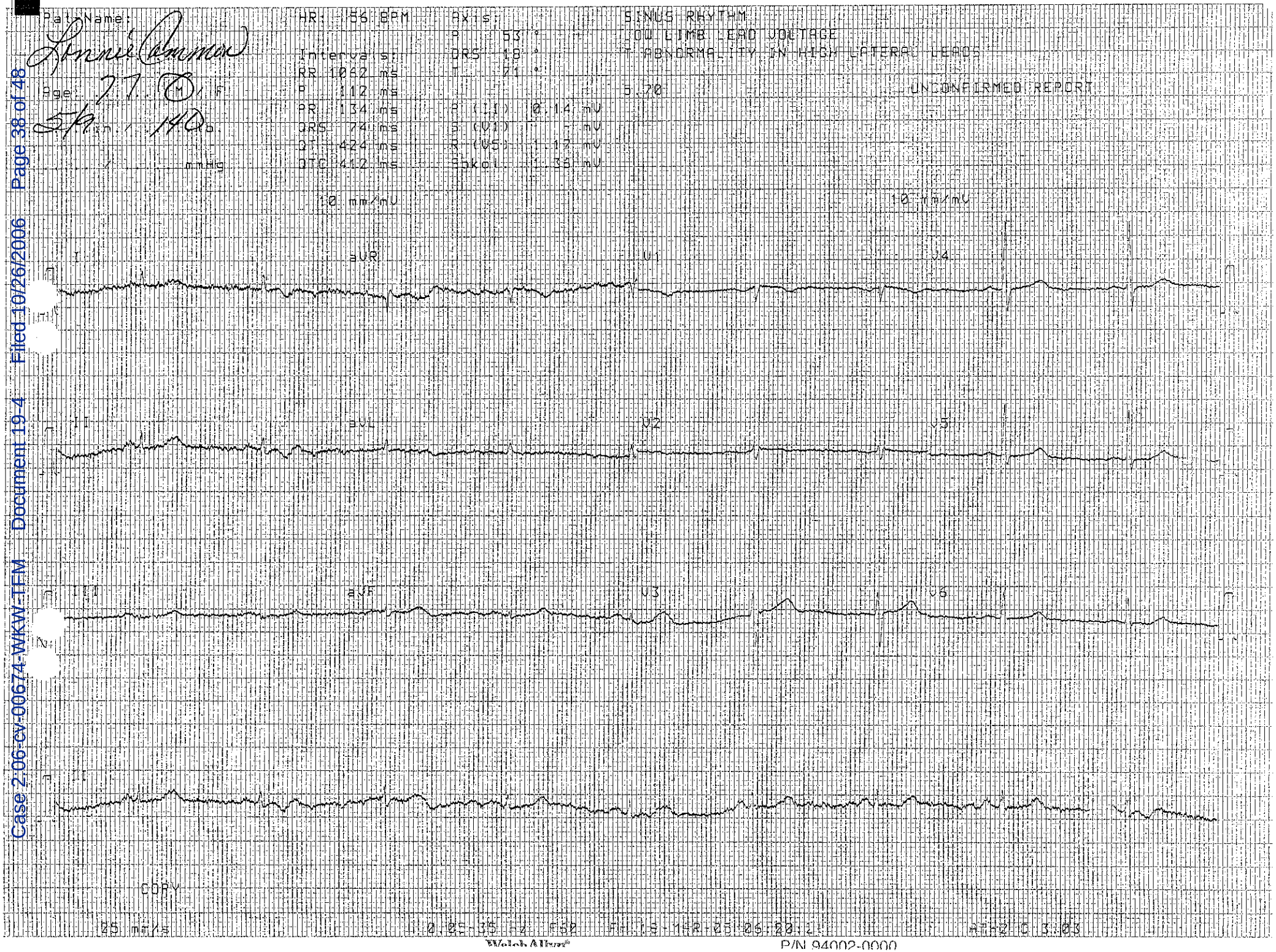


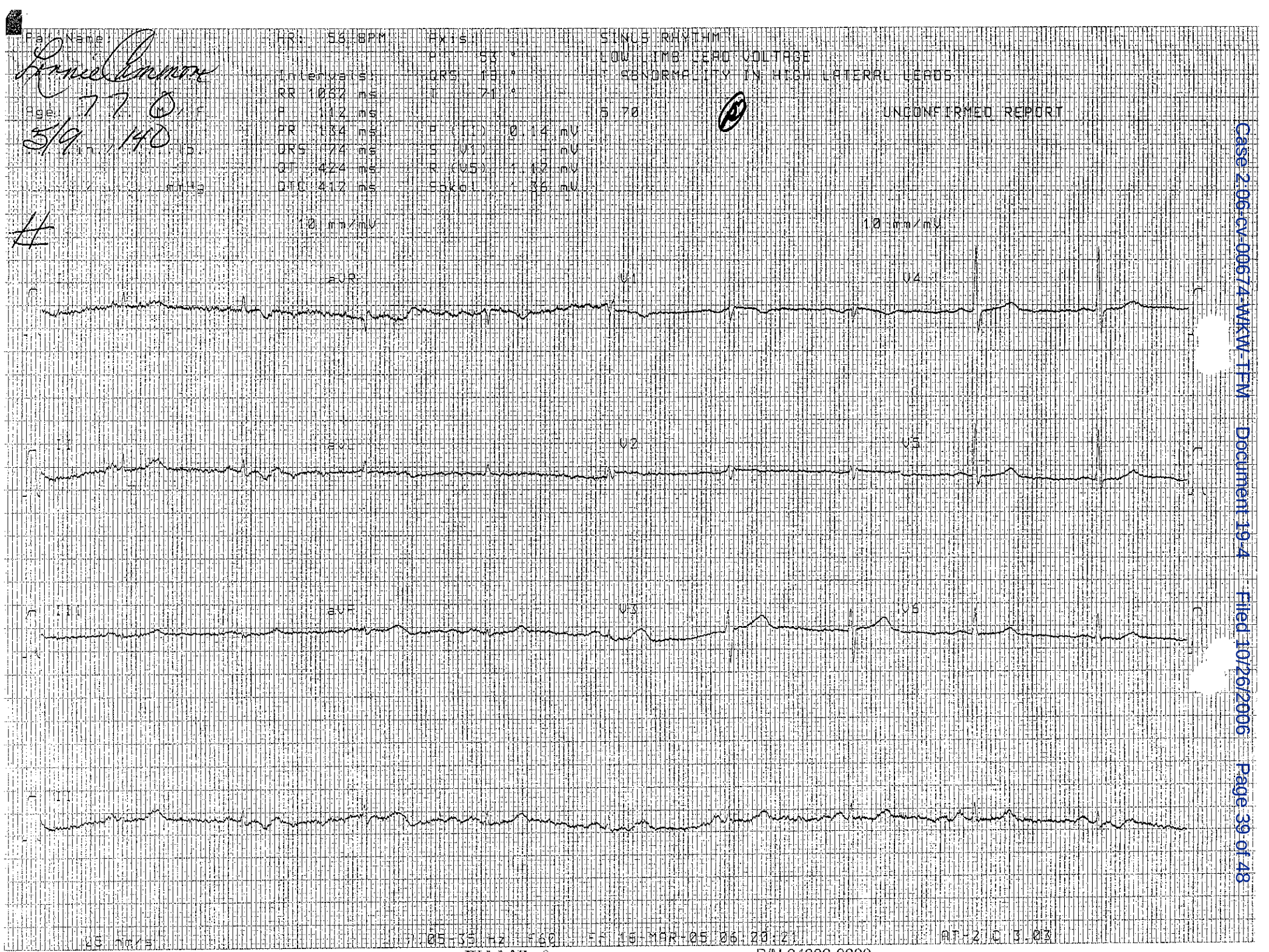
PROGRESS NOTES:

RECORD OF TREATMENT

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL

Patient's Last Name	First	Middle	Age	R/S	ID No.
Cammon, Lonnie			44	B/m	238[illegible]





WelchAllyn®

P/N 94002-0000

LabCorp
Laboratory Corporation of America
LabCorp Mo[illegible]ery Hull
543 Hull Street, Montgomery, AL 36104-0000
Phone: 334-263-5745

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
076-684-3118-0	S	YX	COMPLETE	Page #: 1

ADDITIONAL INFORMATION

NPY-3 FASTING: N
DOB: [redacted]

PATIENT NAME	SEX	AGE(YR /MOS.)
CAMMON,LONNIE	M	77 /

PT. ADD.:

DATE OF SPECIMEN	TIME	DATE RECEIVED	DATE REPORTED	TIME	
3/17/2005	6:00	3/17/2005	3/17/2005	17:10	4206

CLINICAL INFORMATION
CD-41139314893

PHYSICIAN ID	PATIENT ID
ROBBINS M	238498

ACCOUNT: Kilby Correctional Facility
Prison Health Services
12201 Wares Ferry Road
Mt Meigs AL 36507-0000
ACCOUNT NUMBER: 01306900

	TEST	RESULT		LIMITS	LAB
	CBC With Differential/Platelet				
	White Blood Cell (WBC) Count	6.0	x10E3/uL	4.0 - 10.5	YX
	Red Blood Cell (RBC) Count	4.69	x10E6/uL	4.10 - 5.60	YX
	Hemoglobin	14.7	g/dL	12.5 - 17.0	YX
	Hematocrit	44.7	%	36.0 - 50.0	YX
	MCV	95	fL	80 - 98	YX
	MCH	31.3	pg	27.0 - 34.0	YX
	MCHC	32.8	g/dL	32.0 - 36.0	YX
>	RDW	15.2H	%	11.7 - 15.0	YX
	Platelets	252	x10E3/uL	140 - 415	YX
	Neutrophils	46	%	40 - 74	YX
	Lymphs	35	%	14 - 46	YX
	Monocytes	8	%	4 - 13	YX
>	Eos	10 H	%	0 - 7	YX
	Basos	1	%	0 - 3	YX
	Neutrophils (Absolute)	2.8	x10E3/uL	1.8 - 7.8	YX
	Lymphs (Absolute)	2.1	x10E3/uL	0.7 - 4.5	YX
	Monocytes(Absolute)	0.5	x10E3/uL	0.1 - 1.0	YX
>	Eos (Absolute)	0.6H	x10E3/uL	0.0 - 0.4	YX
	Baso (Absolute)	0.1	x10E3/uL	0.0 - 0.2	YX

LAB: YX LabCorp Montgomery Hull DIRECTOR: Alton Sturtevant B PhD
543 Hull Street, Montgomery, AL 36104-0000

Results are Flagged in Accordance with Age Dependent Reference Ranges
Last Page of Report

Bureau Clinical Laboratories-Mo gomery

PC OX 244018, MONTGOMERY ALABAMA 361244018
Phone:(334)260-3400 FAX:(334)274-9800

Page: 1

Provider:			Patient:
KILBY CORRECTIONAL FACILITY	Accession 4006234	ID: 33532	Cammon,Lonnie,
P O BOX 150	Requisition #: 4006234		D O B : [redacted]7 YRS 1 MOS 4
MT MEIGS, ALABAMA, 360570000	Service Area:	Collected: 3/17/2005 @	Sex: M MALE
(334) 215-6600	CHR #:	Received: 3/21/2005 @ 9:17 AM	Phone: (000) 000-0000
MONTGOMERY CO HD		Reported: 3/24/2005 @ 3:09 PM	Status: Final Report

Test Name	Result		Units	Normal Range	Notes
Serology Results					
~ VDRL, STS Quantitative	Reactive 1 dil.	A			
~ TP-PA Result	Reactive	A			

Report Summary

Test Name	Result	
Abnormal Summary		
~ VDRL, STS Quantitative	Reactive 1 dil.	A
~ TP-PA Result	Reactive	A

Needs TX/ H.D 4-4-05 B finished TX 4-20-05

Lab Director
William J. Callan,Ph.D

Date Printed: 3/24/2005	3:09 PM	>> PH - Panic High	>	AH - Abnormal High	~	A - Abnormal	*** Final Page ***
Completed Between: 3/22/2005 -	3/24/2005	<< PL - Panic Low	<	AL - Abnormal Low	δ	Delta Check Failed	All Results Included

308-397-0110-0 | Type | Primary L | Status | Pg 1
Coll Time 03:40

LabCorp® 1.21
Fasting: Y

Additional Information

CD-- 516541362S4

CAMMON, LONNIE | M | Age (Yr/Mos)

Patient Address

Date Collected 05 | Date Received 05 | Date Reported 05 | 5589

Clinical Information

Physician ID DARBOUZE Easterling Corr. | Patient ID 238498 Facility 01488855

Account
Epison Health Services
200 Wallace Dr. 01
Clio AL 36017-0010
334-397-4471
PROV:

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Chemistries					MB
Glucose, Serum	93		mg/dL	65 - 99	MB
Uric Acid, Serum	7.0		mg/dL	2.4 - 8.2	MB
BUN	14		mg/dL	5 - 26	MB
Creatinine, Serum	1.1		mg/dL	0.5 - 1.5	MB
BUN/Creatinine Ratio	13			8 - 27	
Sodium, Serum	140		mmol/L	135 - 148	MB
Potassium, Serum	4.4		mmol/L	3.5 - 5.5	MB
Chloride, Serum	106		mmol/L	96 - 109	MB
Carbon Dioxide, Total	22		mmol/L	20 - 32	MB
Calcium, Serum	9.8		mg/dL	8.5 - 10.6	MB
Phosphorus, Serum	3.7		mg/dL	2.5 - 4.5	MB
Protein, Total, Serum	7.6		g/dL	6.0 - 8.5	MB
Albumin, Serum	4.4		g/dL	3.5 - 5.5	MB
Globulin, Total	3.2		g/dL	1.5 - 4.5	
A/G Ratio	1.4			1.1 - 2.5	
Bilirubin, Total	0.3		mg/dL	0.1 - 1.2	MB
Alkaline Phosphatase, Serum	84		IU/L	25 - 160	MB
LDH	188		IU/L	100 - 250	MB
AST (SGOT)	20		IU/L	0 - 40	MB
ALT (SGPT)	14		IU/L	0 - 55	MB
GGT	29		IU/L	0 - 65	MB
Iron, Serum	98		ug/dL	40 - 155	MB
					MB
Lipids					MB
Cholesterol, Total	139		mg/dL	100 - 199	MB
Triglycerides	91		mg/dL	0 - 149	MB
HDL Cholesterol	31	Low	mg/dL	40 - 59	MB
VLDL Cholesterol Cal	18		mg/dL	5 - 40	
LDL Cholesterol Calc	90		mg/dL	0 - 99	
T. Chol/HDL Ratio	4.5		ratio units	0.0 - 5.0	
Estimated CHD Risk	0.8		times avg.	0.0 - 1.0	

T. Chol/HDL Ratio

	Men	Women
1/2 Avg. Risk	3.4	3.3
Avg. Risk	5.0	4.4
2X Avg. Risk	9.6	7.1
3X Avg. Risk	23.4	11.0

The CHD Risk is based on the T. Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

11/7/05

FINAL

LabCorp Laboratory Corporation of America

LabCorp Birmingham
1801 First Avenue South, Birmingham AL 35233-0000
Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
087-205-5474-0	S	MB	COMPLETE	Page #: 1

ADDITIONAL INFORMATION

OPC FASTING: N
DOB [redacted]

PATIENT NAME	SEX	AGE(YR/MOS)
CAMMON,LONNIE	M	77 / 1

PT. ADD.:

DATE OF SPECIMEN	TIME	DATE RECEIVED	DATE REPORTED	TIME	
3/28/2005	11:13	3/28/2005	3/29/2005	7:14	4566

CLINICAL INFORMATION
CD-4113931526O

PHYSICIAN ID: ROBBINS M
PATIENT ID: 238498

ACCOUNT: Kilby Correctional Facility
Prison Health Services
12201 Wares Ferry Road
Mt. Meigs AL 36507-0000
ACCOUNT NUMBER: 01306900

TEST	RESULT		LIMITS	LAB
Urinalysis, Routine				
Urinalysis Gross Exam				MB
Specific Gravity	1.019		1.005 - 1.030	MB
pH	5.5		5.0 - 7.5	MB
Urine-Color	Yellow		Yellow	MB
Appearance	Clear		Clear	MB
WBC Esterase	Negative		Negative	MB
Protein	Negative		Negative/Trace	MB
Glucose	Negative		Negative	MB
Ketones	Negative		Negative	MB
Occult Blood	Negative		Negative	MB
Bilirubin	Negative		Negative	MB
Urobilinogen,Semi-Qn	0.0	mg/dL	0.0 - 1.9	MB
Nitrite, Urine	Negative		Negative	MB
Microscopic Examination				MB
Microscopic follows if indicated.				

LAB: MB LabCorp Birmingham DIRECTOR: John Elgin N MD
1801 First Avenue South, Birmingham, AL 35233-0000

HCX

HEALTHCARE-CORRECTIONS

E-6

Name: Cammon, Lonnie

State ID No: 238498

DOB: [redacted]

Race: B Sex: m

RADIOLOGY SERVICES REQUEST AND REPORT

INSTITUTION: KCF (PE)

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA (NP)	Date of request	Time of request	Routine	Priority	Transportation or special needs
m Webb	3-17-05	9:25 Am	—		

HISTORY/DIAGNOSIS:

protocal

X-RAY REQUEST

	ABDOMEN/KUB		FINGERS		NAVICULAR VIEW		SOFT TISSUE STUDIES
	ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)		FOOT		ORBITS		STERNUM
	ANKLE		HAND		OS CALCIS (HEEL)		TEMPORO-MANDIBULAR JOINTS
	CERVICAL SPINE		HIP		PELVIS		THORACIC SPINE
A	CHEST PA / LATERAL		HUMERUS		RADIUS/ULNA		TIBIA/FIBULA
	COCCYX		KNEE		RIBS		TOES
	CONE DOWN SELLA TURCICA		LUMBAR SPINE		SACRO-ILIAC JOINTS		WRIST
	ELBOW		MANDIBLE		SCAPULA		ZYGOMA
	FACIAL BONES		MAXILLA		SHOULDER		ZYGOMATIC ARCH
	FEMUR		NASAL BONES		SKULL		

Cammon

REPORT

Chest: The heart is not enlarged. The lungs are clear.
IMPRESSION: THERE IS NO EVIDENCE OF ACTIVE CARDIOPULMONARY DISEASE.

NOTE: There has been surgery involving the right shoulder.

D & T: 03-18-05 Maurice H. Rowell/rr Board Certified Radiologist (Signature on File)

3/21/05

KA, RT

X-RAY TECHNOLOGIST'S NAME (PRINT) | X-RAY TECHNOLOGIST'S SIGNATURE | DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT) | RADIOLOGIST'S SIGNATURE | DATE SIGNED

LabCorp
Laboratory Corporation of America

LabCorp Birmingham
1801 First Avenue South Birmingham, AL 35233-0000
Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
077-205-5225-0	S	MB	COMPLETE	Page #: 1

ADDITIONAL INFORMATION

PHY-3 3/17 FASTING: N DOB: [redacted]

PATIENT NAME	SEX	AGE(YR/MOS)
CAMMON,LONNIE	M	77 /

PT. ADD :

DATE OF SPECIMEN	TIME	DATE RECEIVED	DATE REPORTED	TIME	
3/18/2005	7:36	3/18/2005	3/19/2005	7:16	4255

CLINICAL INFORMATION
CD-41139314954

PHYSICIAN ID: ROBBINS M
PATIENT ID: 238498

ACCOUNT: Kilby Correctional Facility
Prison Health Services
12201 Wares Ferry Road
Mt Meigs AL 36507-0000
ACCOUNT NUMBER: 01306900

	TEST	RESULT		LIMITS	LAB
	CMP14+LP+5AC				
	Chemistries				MB
	Glucose, Serum	79	mg/dL	65 - 99	MB
	Uric Acid, Serum	6.9	mg/dL	2.4 - 8.2	MB
	BUN	19	mg/dL	5 - 26	MB
	Creatinine, Serum	1.2	mg/dL	0.5 - 1.5	MB
	BUN/Creatinine Ratio	16		8 - 27	
>	Sodium, Serum	150 H	mmol/L	135 - 148	MB
	Potassium, Serum	4.4	mmol/L	3.5 - 5.5	MB
>	Chloride, Serum	111 H	mmol/L	96 - 109	MB
	Carbon Dioxide, Total	20	mmol/L	20 - 32	MB
	Calcium, Serum	10.5	mg/dL	8.5 - 10.6	MB
	Phosphorus, Serum	3.5	mg/dL	2.5 - 4.5	MB
	Protein, Total, Serum	7.9	g/dL	6.0 - 8.5	MB
	Albumin, Serum	4.4	g/dL	3.5 - 4.8	MB
	Globulin, Total	3.5	g/dL	1.5 - 4.5	
	A/G Ratio	1.3		1.1 - 2.5	
	Bilirubin, Total	0.5	mg/dL	0.1 - 1.2	MB
	Alkaline Phosphatase, Serum	114	IU/L	25 - 160	MB
>	LDH	256 H	IU/L	100 - 250	MB
	AST (SGOT)	24	IU/L	0 - 40	MB
	ALT (SGPT)	16	IU/L	0 - 40	MB
	GGT	24	IU/L	0 - 65	MB
>	Iron, Serum	173 H	ug/dL	40 - 155	MB
					MB
	Lipids				MB
>	Cholesterol, Total	218 H	mg/dL	100 - 199	MB
	Triglycerides	101	mg/dL	0 - 149	MB
>	HDL Cholesterol	31 L	mg/dL	40 - 59	MB
	VLDL Cholesterol Cal	20	mg/dL	5 - 40	
>	LDL Cholesterol Calc	167 H	mg/dL	0 - 99	
	Comment				MB

If initial LDL-cholesterol result is >100 mg/dL, assess for risk factors and refer to the ATP-III table below.

Risk Category	LDL Goal mg/dL	LDL Level (mg/dL) at which to initiate Therapeutic Lifestyle Changes (TLC)	LDL Level (mg/dL) at which to consider Drug Therapy

LabCorp Laboratory Corporation of America

LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000
Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	
077-205-5225-0	S	MB	COMPLETE	Page #: 2

ADDITIONAL INFORMATION

PHY-3
3/17
FAST[redacted]
DOB[redacted]

PATIENT NAME	SEX	AGE(YR/MOS)
CAMMON,LONNIE	M	77 /

PT. ADD.:

DATE OF SPECIMEN	TIME	DATE RECEIVED	DATE REPORTED	TIME	
3/18/2005	7:36	3/18/2005	3/19/2005	7:16	4255

CLINICAL INFORMATION
CD-41139314954

PHYSICIAN ID	PATIENT ID
ROBBINS M	238498

ACCOUNT: Kilby Correctional Facility
Prison Health Services
12201 Wares Ferry Road
Mt Meigs AL 36507-0000
ACCOUNT NUMBER: 01306900

	TEST	RESULT		LIMITS	LAB
	CHD	<100	>100	>or=130	
	2+ Risk Factors	<130	>or=130	>or=130	
	0-1 Risk Factors	<160	>or=160	>or=190	
>	T. Chol/HDL Ratio	7.0H	ratio units	0.0 - 5.0	
>	Estimated CHD Risk	1.4H	times avg.	0.0 - 1.0	

T. Chol/HDL Ratio

	Men	Women
1/2 Avg. Risk	3.4	3.3
Avg. Risk	5.0	4.4
2X Avg. Risk	9.6	7.1
3X Avg. Risk	23.4	11.0

The CHD Risk is based on the T Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of premature CHD.

Prostate-Specific Ag, Serum

Prostate-Specific Ag, Serum	2.8	ng/mL	0.0 - 4.0	MB

Beckman (formerly Hybritech) ICMA methodology

LAB: MB LabCorp Birmingham DIRECTOR: John Elgin N MD
1801 First Avenue South, Birmingham, AL 35233-0000

Results are Flagged in Accordance with Age Dependent Reference Ranges
Last Page of Report

Faxed 11-18-05 MP

PHS
Prison Health Services, Inc.

LABORATORY NON-FORMULARY REQUEST FORM

Provider: To expedite the processing of this form, ALL sections must be completed and legible.

Site Name & Number: KCF-840	Patient Name: Cammon, Lonnie (Last, First, M.I.)	Date: 03,17,05
Site Phone #: 334.215-6691	Inmate Number: 238498	DOB: [redacted]
Site Fax #: 334.215.6698	Sex: ☒ Male ☐ Female	PHS Custody Date: 03,16,05

Requested Non-Formulary Test

Code #: 010322
Description: PSA
Diagnosis:
What is your justification for this non-formulary test? Protocal

☐ Approved ☐ More Information Needed
☐ Alternative Test Code & Description

Requested Non-Formulary Test

Code #:
Description:
Diagnosis:
What is your justification for this non-formulary test?

☐ Approved ☐ More Information Needed
☐ Alternative Test Code & Description

Practitioner Information:
Name: Robbins (Last) Michael (First) Signature: [signature]
Day/Sun Phone: 334.215.6691 Pager Number: (___) ___-____

It is the requesting practitioner's personal responsibility to legibly fill out all of the above fields. Incomplete non-formulary requests will not be reviewed. Any delay in ordering caused by an incomplete/illegible non-formulary request is the responsibility of the requesting practitioner.

Regional Medical Director Signature: _____ Date: __/__/__

ALABAMA DEPARTMENT OF CORRECTIONS

PROBLEM LIST

INMATE NAME Cammon, Lonnie AIS# 238498

Medication Allergies: NKDA DOB [redacted]

Medical: Chronic (Long-Term) Problems
Roman Numerals for Medical/Surgical

Mental Health Code: SMI HARM HIST NONE
Capital Letter for Psychiatric Behavior

Date Identified	Chronic Medical Problem	Mental Health Code	Date Resolved	Provider Initials
3-19-05	PPD - 0mm 2/7/06			
8/25/05	- D/D Multiple joints			
	- CVA x weakness 1986			
	- Bladder incontinence			
	- Glaucoma OU			
	- Cataract, OS			
	11/22/05 Hep B Vacc. #1 Lot# AHBVB004BA EXP. 01/20/2006			
	12/22/05 Hep. B Vacc. #2 Lot# AHBVB004BA EXP. 01/20/2006			
	- S/P C spine surgery	DDD		
	~~- D/D Multiple joints~~			
5/2/06	cellulitis (L) arm			(112)

**If Asthmatic label: Mild – Moderate – or Severe.

EXHIBIT A-4

Nurse's Chronic Care Clinic

Date: 6/2/06 Time: 0920 Facility: BCF

Check all applicable CICs being evaluated: ✓ Card/HTN __DM __GI __ID __PUL __SZ __TB

Vital Signs: BP 140/60 P 68 R 18 T 98

SUBJECTIVE:

For diabetic patients, list the # of hypoglycemic reactions since the last CIC visit: __ Dates: N/A
See attached for monofilament check.
For asthma patients, list the # of asthma attack visits since the last CIC visit: ____ Dates: N/A
For seizure patients, list the # of witnessed seizures since the last CIC visits: ____ Dates: N/A

ALLERGIES: NKA
MEDICATIONS: Stated
CURRENT DIET: Low Cholesterol
DESCRIBE MED AND DIET ADHERANCE: Compliant
DESCRIBE ANY MED SIDE EFFECTS: None Noted
VACCINES: Flu ____ Pneumovax ____ Hep A ____ Hep B ____
For asthma pts, list the number of short-acting inhaler canisters refilled in the past month ____
(*This should equate to one inhaler per month.)

Lab/Diagnostic test(s) w/ date(s): HbA1c ____ on ____; CD4 & HIV-RNA ____ on ____;
Peak Flow ____; LFTs ____ on ____; Serum Drug Levels ____ on ____; EKG 6/5/06; CXR ____;

Medications:

Mevacor 20mg QD
ASA 325 QD

Patient Educated on: Encouraged on a Low Cholesterol diet

Inmate Signature Lonnie Common

Nurses Signature and Title [illegible]

Common, Lonnie
NAME

238498
AIS

M
GENDER

B
RACE

[redacted]
DOB

(Revised 05/18/05)

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 6/2/06 Time: 0930 Facility: BCCF

Check all applicable CIC's being evaluated: ✓ Card/HTN __DM__GI__ID__PUL__SZ__TB

SUBJECTIVE: No Compl

OBJECTIVE: BP 100/160 HR 68 RR 18 Temp 98 Wt 142 Peak Flow____

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities,; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

[illegible handwriting]

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
Status: I=Improved, S=Stable, W=Worsened

DM			HTN/CARD			SZ			PUL			ID			GI			OTH
Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of
G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G F
Status			Status			Status			Status			Status			Status			Sta
I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I S

PLAN: Contd [illegible] Meds

F/U: Routine 90 days: ______ Other ________ Problem List Updated: Yes

[signature] 6/2/06

Physician/NP/PA

Dammons, Lonnie
NAME

238498
AIS#

M
GENDER

B
RACE

[redacted]
DOB

(Revised 5/18/05)

Nurse's Chronic Care Clinic

Date: 6/2/06 Time: 0920 Facility: Bcf

Check all applicable CICs being evaluated: ✓ Card/HTN __DM__GI__ID__PUL__SZ__TB

Vital Signs: BP 140/80 P 68 R 18 T 98

SUBJECTIVE:

For diabetic patients, list the # of hypoglycemic reactions since the last CIC visit: __Dates:
See attached for monofilament check.
For asthma patients, list the # of asthma attack visits since the last CIC visit: ___Dates: N/A
For seizure patients, list the # of witnessed seizures since the last CIC visits: ___Dates:

ALLERGIES: NKA
MEDICATIONS: Listed CURRENT DIET: Low Cholesterol
DESCRIBE MED AND DIET ADHERANCE: Compliant
DESCRIBE ANY MED SIDE EFFECTS: None noted
VACCINES: Flu ____Pneumovax ____Hep A ____Hep B ____
For asthma pts, list the number of short-acting inhaler canisters refilled in the past month ____
(This should equate to one inhaler per month.)

Lab/Diagnostic test(s) w/ date(s): HbA1c ____on ____; CD4 & HIV-RNA ___/___on ____;
Peak Flow ___: LFTs ___on ____; Serum Drug Levels __on ____; EKG 6/5/06; CXR ___:

Medications:

Mevacor 20mg q/d
ASA 325 po qd

Patient Educated on: Instructed on a Low Cholesterol diet

Inmate Signature Lonnie Common

Nurses Signature and Title [illegible]

Common, Lonnie
NAME

238498
AIS

M
GENDER

B
RACE

[redacted]
DOB

(Revised 05/18/05)

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 6/2/06 Time: 0930 Facility: BCF

Check all applicable CIC's being evaluated: ✓ Card/HTN __DM __GI __ID __PUL __SZ __TB

SUBJECTIVE: No complaints

OBJECTIVE: BP 100/160 HR 68 RR 18 Temp 98 Wt 142 Peak Flow ____

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities,; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen

WNL except

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
Status: I=Improved, S=Stable, W=Worsened

DM				HTN/CARD				SZ				PUL				ID				GI				OTHE			
Degree of Control				Degree of Control				Degree of Control				Degree of Control				Degree of Control				Degree of Control				Degree of			
G	F	P		G	F	P		G	F	P		G	F	P		G	F	P		G	F	P		G	F		
Status				Status				Status				Status				Status				Status				Sta			
I	S	W		I	S	W		I	S	W		I	S	W		I	S	W		I	S	W		I	S		

PLAN: Continue BBM Measures

F/U: Routine 90 days: _____ Other _____ Problem List Updated: Yes

6/2/06

Physician/NP/PA

Dawson, Lonnie

NAME

238498

AIS#

M

GENDER

B

RACE

[redacted]

DOB

(Revised 5/18/05)

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 5/2/06 Time: 7²⁰am Facility: ECF

Check all applicable CIC's being evaluated: (Card)/HTN __DM__GI__ID__PUL__SZ__TB

SUBJECTIVE: 78 BM for ccc c̄ O2Sat 95%
Hx (R) CVA Hx swollen (L) arm c̄ pain reported

OBJECTIVE: BP 110/60 HR 80 RR 16 Temp 97.8 Wt 134 Peak Flow____ ✓ 3/06

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities,; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

NAD VSS
HEENT Eom perrla Blind (L) eye DT cataract
Cor RRR ⊖ JVD
Lungs CTA
ABD soft NT
Ext ⊖ECC Bil Ext (L) arm warm to touch tender to palp
PP 14 DP 2+ Bil
Equal strength Bil ↑↓ cap refill <3 sec

⊖ SOB
⊖ N/V
⊖ Chest pains today

chem 7
29/1.2 (L)
138/4.7
LFT WNL
CBC

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
G F P	G F P	G F P	G F P	G F P	G F P	G F P
Status	Status	Status	Status	Status	Status	Status
I S W	I S W	I S W	I S W	I S W	I S W	I S W

PLAN: Cont current med tx Plan c̄ compliance to meds / tx plan
↓ Salt ↓ Fat Diet c̄ ↑ Exercise as tolerated

F/U: Routine 90 days: ✓ Other ______ Problem List Updated: (Yes) No

~~LASIX 40mg daily X 3 days~~ error (ID)
Bactrim DS i po BID X10 days
elevate (L) arm BID X 3 months

[signature] Physician/NP/PA

Cammon Lonnie
NAME

238498
AIS#

[redacted]
DOB

M
GENDER

B
RACE

(Revised 2/28/05)

PRISON HEALTH SERVICES

Nurse's Chronic Care Clinic

Date: 5/2/06 Time: 730am Facility: ECF

Check all applicable CICs being evaluated: (Card/HTN) __DM__GI__ID__PUL__SZ __TB

Vital Signs: BP_____P_____R_____T_____

SUBJECTIVE:

For diabetic patients, list the # of hypoglycemic reactions since the last CIC visit: __Dates:_____
See attached for monofilament check.
For asthma patients, list the # of asthma attack visits since the last CIC visit: ____Dates:_____
For seizure patients, list the # of witnessed seizures since the last CIC visits: ____Dates:_____

ALLERGIES: NKDA CURRENT DIET: Reg -
MEDICATIONS:
DESCRIBE MED AND DIET ADHERANCE:
DESCRIBE ANY MED SIDE EFFECTS:
VACCINES: Flu_____Pneumovax _____ Hep A _____ Hep B_____
For asthma pts, list the number of short-acting inhaler canisters refilled in the past month_____
(*This should equate to one inhaler per month.)

Lab/Diagnostic test(s) w/ date(s): HbA1c_____ on_____: CD4 & HIV-RNA ___/___on_____
Peak Flow___: LFTs____on _____; Serum Drug Levels __ on _____; EKG 2/06 CXR 4/06

Medications: Mevacor 40mg bid
EC ASA 325mg qd

CMP - } 3/06
CBC - }
LP - } 11/05

Patient Educated on: (IP) 5/2/06

Inmate Signature X Lonnie Common

Nurses Signature and Title Shushupi

Common Lonnie
NAME

238498
AIS

M
GENDER

B
RACE

[redacted]
DOB

01/31/05
Revised 5/18/2005

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 2/7/06 Time: 1:30p Facility: Easterling

Check all applicable CIC's being evaluated: ✓ Card/HTN __DM__GI__ID__PUL__SZ__TB

SUBJECTIVE: f/u 57 B/M. h/o CVA - R weakness - resolved. c/o pain to multiple joints - Denies weakness/numbness

OBJECTIVE: BP 158/92 HR 62 RR 18 Temp 95.4 Wt ____ Peak Flow ____

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities,; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

140 | 14 | (9
4.4 | 1.1 |

NAD. BP: 158/92 P: 62

HEENT: [illegible]

HDL: 31
LDL: 90

Lung: CTA

Heart: RRR

Ext: ∅ edema

Abd: benign

C spine: nl

L Arm: + mild edema + tenderness at [illegible]

Neuro: intact

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER (CVA)
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
G F P	G F P	G F P	G F P	G F P	G F P	G (F) P
Status	Status	Status	Status	Status	Status	Status
I S W	I S W	I S W	I S W	I S W	I S W	I (S) W

PLAN: - Continue ASA, Minipress.
- Daily aerobic exercise, ↓ salt/fat/chol intake
- BP + f ✓

F/U: Routine 90 days: X Other ______ **Problem List Updated:** (Yes) No

______ MD
Physician/NP/PA

Cannon, Lonnie
NAME

238498
AIS#

M
GENDER

B
RACE

[redacted]
DOB

(Revised 2/28/05)

F..ISON HEALTH SERVICES

Nurse's Chronic Care Clinic

Date: 2/7/06 Time: 1 pm Facility: Ewaley

Check all applicable CICs being evaluated: ✓Card/HTN __DM__GI__ID__PUL__SZ __TB

Vital Signs: BP 158/92 P 62 R 18 T 95

SUBJECTIVE:

For diabetic patients, list the # of hypoglycemic reactions since the last CIC visit: __Dates:_____
See attached for monofilament check.
For asthma patients, list the # of asthma attack visits since the last CIC visit: ____Dates:_____
For seizure patients, list the # of witnessed seizures since the last CIC visits: ____Dates:_____

ALLERGIES: NKA CURRENT DIET:_____
MEDICATIONS:_____
DESCRIBE MED AND DIET ADHERANCE:_____
DESCRIBE ANY MED SIDE EFFECTS:_____
VACCINES: Flu_____Pneumovax _____ Hep A _____ Hep B_____
For asthma pts, list the number of short-acting inhaler canisters refilled in the past month._____
(*This should equate to one inhaler per month.)

Lab/Diagnostic test(s) w/ date(s): HbA1c_____ on_____: CD4 & HIV-RNA ___/___on_____;
Peak Flow___: LFTs____on _____; Serum Drug Levels __ on _____; EKG _____; CXR___;

Medications: Diltiazem 5mg b.i.d
EC ASA 325g PO
Mevacor 40g b.i.d
NTG SL PRN

Patient Educated on:
Taking medication daily

Inmate Signature_____

Nurses Signature and Title J Mckinnon

Cammon, Lonnie
NAME

238498
AIS

M
GENDER

B
RACE

[redacted]
DOB

01/31/05
Revised 5/18/2005

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 11/17/05 Time: 11^20 am Facility: ECF

Check all applicable CIC's being evaluated: (Card)/HTN __DM__GI__ID__PUL__SZ__TB (CVA)

SUBJECTIVE: 77 BM - s/p CVA with R weakness - c/o back pain non radiating worse with work/exertion. No chest pain, SOB, dizziness

OBJECTIVE: BP 120/70 HR 63 RR 16 Temp 97 Wt 120 Peak Flow____

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities,; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

NAD, AOx3 — Heart: regular, murmur — 140 | 14 | 93 / 4.4 | 1.1

Lungs: clear — Abdomen: NAD

Abd: benign — Ext: ∅ edema — Tot cholest: 139

HDL: 31

LDL: 90

Neuro: A.O. x3 - CNs: intact — good coordination and equilibrium. Bright

HgbA1c: 4.7

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
Status: I=Improved, S=Stable, W=Worsened

DM			HTN/CARD			SZ			PUL			ID			GI			OTHER (CVA)		
Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control		
G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	(F)	P
Status			Status			Status			Status			Status			Status			Status		
I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	(S)	W

PLAN: - continue current tx - Tylenol prn
- daily aerobic exercise, low salt / fat
- Tylenol (q) for MD Rx

F/U: Routine 90 days: X Other ______ Problem List Updated: (Yes) No

Physician/NP/PA

Cammon Lonnie
NAME

238498
AIS#

M
GENDER

B
RACE

[redacted]
DOB

(Revised 2/28/05)

PRISON HEALTH SERVICES

Nurse's Chronic Care Clinic

Date: 11/17/05 Time: 11^30 Facility: ECF

Check all applicable CICs being evaluated: _Card/HTN (circled) __DM__GI__ID__PUL__SZ__TB CVA

Vital Signs: BP 120/70 **P** 63 **R** 16 **T** 97

SUBJECTIVE:

For diabetic patients, list the # of hypoglycemic reactions since the last CIC visit: __Dates:________
See attached for monofilament check.
For asthma patients, list the # of asthma attack visits since the last CIC visit: ____Dates:________
For seizure patients, list the # of witnessed seizures since the last CIC visits: ____Dates:________

ALLERGIES: NKDA CURRENT DIET:________
MEDICATIONS:
DESCRIBE MED AND DIET ADHERANCE:________
DESCRIBE ANY MED SIDE EFFECTS: ________
VACCINES: Flu_____Pneumovax _____ Hep A ________ Hep B________
For asthma pts, list the number of short-acting inhaler canisters refilled in the past month.________
(*This should equate to one inhaler per month.)

Lab/Diagnostic test(s) w/ date(s): HbA1c_____ on_______; CD4 & HIV-RNA ___/___on_________;
Peak Flow___; LFTs____on ________; Serum Drug Levels __ on ________; EKG 10/05; CXR___;

Medications:
EC ASA 325mg qd
Ditropan 5mg bid
Mevacor 40mg bid

CMP14 } 11/05
Lipids }

Patient Educated on: med compliance

Inmate Signature x Lonnie Cammon

Nurses Signature and Title S Buskum

Cammon Lonnie
NAME

238498
AIS

M
GENDER

B
RACE

[redacted]
DOB

01/31/05
Revised 5/18/2005

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 8/23/05 Time: 14:15 Facility: Easterling

Check all applicable CIC's being evaluated: (Card/HTN) __DM__GI__ID__PUL__SZ__TB

SUBJECTIVE: 77 BM - s/p CVA c weakness 1986, ↑ chol/t - bladder [illegible] s/p [illegible]

OBJECTIVE: BP 104/70 HR 72 RR 17 Temp 98 Wt 128 Peak Flow____

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities,; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

HEENT: [illegible] Heart: nl ø [illegible] HDL: 31

Lungs: CTA [illegible] LDL: 167

Abd: benign [illegible] 150 | 19 | [illegible]

Neuro: intact ... ↓ strength ... (4+) 4.4 | 1.2 |

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
Status: I=Improved, S=Stable, W=Worsened

DM	HTN/CARD	SZ	PUL	ID	GI	OTHER (CVA)
Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control	Degree of Control
G F P	G F P	G F P	G F P	G F P	G F P	G (F) P
Status	Status	Status	Status	Status	Status	Status
I S W	I S W	I S W	I S W	I S W	I S W	I (S) W

PLAN: - Start ASA, Mevacor
- Daily [illegible] exercise - walking and strength
- Lab in [illegible] weeks

F/U: Routine 90 days: X Other ______ Problem List Updated: (Yes) No

______ MD
Physician/NP/PA

Gammon Lonnie
NAME

238498
AIS#

M
GENDER

B
RACE

[redacted]
DOB

(Revised 5/18/05)

PRISON HEALTH SERVICES, INC

HEALTH EVALUATION

I. HISTORY – (LPN or RN)	YES	NO	COMMENT(S)
Weight Change (greater 15 lbs.) (Compare Weight Below)		✓	Last weight at least 6 months ago
Persistent Cough		✓	
Chest Pain		✓	
Blood in Urine or Stool		✓	
Difficult Urination		✓	
Other Illnesses (Details)	✓		See Problem list
Smoke, Dip or Chew		✓	
ALLERGIES		✓	

Weight 138 Temp 98' Pulse 76 Resp 16 Blood Pressure 120/70

If greater than > 140/60, repeat in 1hour.
Refer to M.D. if remains > 140/90

Eye Exam: 20/50 OD 20/200 OS 20/40 OU

II. TESTING – (LPN or RN)	RESULTS
Tuberculin Skin Test (q yr)	Date given 3/15/06 Site LFA Read on 3/18/06 Results 0 mm
Past Positive TB Skin Test →	**Survey Completed**
(Chest x-ray if clinical symptoms)	Date ____ Results ____
RPR (q 3 yrs)	Date 3/05 Results R
EKG (baseline at 35, over 45 q 3 yrs)	2/04
Cholesterol (at 35 then q 5 yrs)	11/05
Finger Stick Blood Sugar	Results 81
* If > than 200 repeat Finger Stick BS within 48 hours	Results
Optometry Exam (@ 50 if not already seen)	2/7/06
Mammogram (females @ 40, q 2 yrs/other M.D. order)	Date ____ Results ____

III. PHYSICAL RESULTS – (RN, Mid-Level, M.D.)		
Heart	RRR	
Lungs	Clear	
Breast Exam		
Rectal (yearly after 45)	Results normal	3/27/06
with Hemoccult	Results negative	
Pelvic and PAP (q 1 yr)	Date ____ Results ____	

appt. made

Facility ECF Nurse Signature SBuchan LPN Date 3/15/06

M.D. or Mid-Level Signature ____ Date 3/17/06

INMATE NAME	AIS#	D.O.B.	RACE/SEX
Cammon Lonnie	238198	[redacted]	B/m

PHS PRISON HEALTH SERVICES INCORPORATED

INTAKE HEALTH EVALUATION

NAME: Cammon, Lonnie
AIS #: 238498
D.O.B.: [redacted]

Age 77 Sex M Race B Height 5'9 Weight 140

Temp: 97.1 B/P: 118/68 Pulse: 78 Resp: 20
** B/P – If greater than 140/90, repeat in 1 hour. Refer to Mid-Level if B/P remains up.

Do you now or have you ever had, or been treated for:

Problem	Y	N	Problem	Y	N	Problem	Y	N
Head Trauma		✓	Gastritis		✓	**HIV/AIDS** ***		✓
Loss of Consciousness		✓	Ulcers		✓	***Medications Verified		
Severe Headaches		✓	Bleeding		✓	Hepatitis - Type		✓
Vertigo/Dizziness		✓	Gall Bladder/Pancreas		✓	Gonorrhea		✓
Glaucoma, Cataracts Vision Problems	✓		Liver Problems		✓	Syphilis		✓
Hearing Problems		✓	Arthritis	✓		Lice, Crabs, Scabies		✓
Seizures		✓	Joint Muscle Problem		✓			
Strokes	✓		Back/Neck Problem		✓	**LMP**		
Nervous Disorders		✓	Kidney Stones/Dz		✓	Date		
DT's		✓	Bladder/Kidney Infection	✓		Duration		
Heart Condition		✓	Alcoholism	✓		Normal		
Angina/Heart Attack		✓	Drug Abuse		✓	Regularity		
High Blood Pressure		✓	Psychiatric History		✓	Gravida/Para		
Anemia/Blood Disorder		✓	Suicidal Thoughts**		✓	AB/Miscarriage		
Sickle Cell or Trait		✓	**Immediate M.H. Referral			Contraception		
Lung Condition		✓	**T.B.**		✓	Type:		
Asthma *		✓	PPD - date given: 3-17-05					
*Peak Flow Reading			RFA (LFA)			**Lab Tests - Dates**	N	Ab
Bronchitis		✓	Date read: 3-19-05			Diagnostic Profile II		
Emphysema		✓	Results: 0 mm		✓	RPR		
Pneumonia		✓	**Visual Acuity**			Urine Dip Stick		
Diabetes		✓	OD 20/50 OS 20/200					
Hay Fever/Allergies		✓	OU 20/40 Eyeglasses			EKG (@ age 35)		

Immunization History: Td > 10yrs

Immunizations Needed: Td 0.5cc (R) deltoid

Lot U1212BA Tetanus and Diphtheria Toxoids Adsorbed For Adult Use, DECAVAC™ US Govt Lic #1277 Mfd by: Aventis Pasteur Inc Swiftwater PA 18370 USA CPT® Code: 90718 — 0.5 mL — Rx only — 4934

***HIV Medications: Ø

Acute or Chronic Problem Noted: (Y) N Refer to Mid-Level or M.D. if yes.

RN or Mid-Level, Signature

Date/Time 03/17/05 0940

60511-AL

I have read the *access to health care* information sheets and have been given a copy I understand how to access health care

Name Lonnie Cammon Date 3/7/05

AIS# 238498

Medical Staff JHardy, NP Date 3-17-05

PHS
PRISON HEALTH SERVICES INCORPORATED

INTAKE SCREENING

Date: 03/16/05 AIS#: 238498

Last Name: Cammon First: Bonnie Middle: O

Birthplace: Chambers County DOB: [redacted] SS#: [redacted]

~~FEMALES:~~ Pregnancy test: (circle one) ~~Positive~~ ~~Negative~~

B/P 110/76 Temp 97.9 Pulse 62 Resp 16 Weight 140

FSBS 79 If level > 200, repeat within 48 hours. Above 300 call M.D.

Previous Hospitalizations/Surgeries/Major Illness/Current Illness: What? Where?

R shlde surgery, Arthritis, Stroke

Previous Incarcerations (Date & Facility)

O

Medications: ☐ None Lortab

Allergies: ☑ ~~NKA~~

Special Diet (Prescribed)

Past Positive TB Skin Test (circle one) YES - (Complete TB Screening Form) (NO)

ANY INMATE WHO IS UNCONSCIOUS, SEMICONSCIOUS, ACTIVELY BLEEDING IN ACUTE PAIN AND URGENTLY IN NEED OF MEDICAL ATTENTION SHOULD IMMEDIATELY BE REFERRED FOR EMERGENCY CARE

CLINICAL OBSERVATIONS

1) Level of Consciousness: ~~( ) Alert~~ ~~( ) Oriented~~; time, place, person ( ) Lethargic ( ) Stuporous ( ) Comatose

Describe:

2) General Appearance ~~( ) Normal~~ ( ) Abnormal

3) Signs of Trauma ( ) Yes ~~( ) No~~

3) Substance Abuse: ( ) Yes ( ) No ( ) Suspected

( ) Current intoxication/Abuse ( ) Use ( ) Withdrawal Symptoms

( ) Drugs ~~( ) Alcohol~~ a beer or 2

Describe- What kind? Amount/Frequency?

• If confirmed Benzo use then call M.D If can not be confirmed call M.D

Last Use: (Time(Date):

4a) Behavior/Conduct: ~~( ) Calm~~ ( ) Cooperative ( ) Non-Violent ( ) Agitated ( ) Uncooperative ( ) Violent ( ) Manipulative ( ) Disorganized

Describe:

4b) Affect/Mood: ( ) Normal ( ) Manic ~~( ) Depressed~~ ( ) Euphoria ( ) Flat ( ) Emotionally Confused

Describe:

4c) Perceptions: ( ) Delusional ( ) Hallucinations ( ) Hearing Voices

5a) Is there h/o actual suicide attempt? ( ) Yes ~~( ) No~~

5b) Does pt describe current suicidal thoughts or ideations? ( ) Yes ~~( ) No~~

5c) Is there evidence

5d) High risk pt may become assaultive towards staff? ( ) Yes ~~( ) No~~

If ANY of the above in #5 are circled staff MUST describe here include previous history and dates:

***Any abnormal observations #4 or 5 require immediate Mental Health Referral.**

Triggers for Suicide Watch
- Currently Suicidal
- History of actual attempt
- Fails to maintain control on Close Watch Y or N

Triggers for Close Watch
- Emotionally distraught and unable to regain composure by end of intake process
- Actively hallucinating or not making any sense Y or N

6a) Communication Difficulties ( ) Yes ~~( ) No~~

6b) Memory Defects ~~( ) Yes~~ ( ) No

6c) Hearing Impairment ~~( ) Yes~~ ( ) No

6d) Speech Difficulties ( ) Yes ~~( ) No~~

7) Physical Aids: ( ) None ~~( ) Glasses~~ ( ) Contacts ( ) Hearing Aid ~~( ) Dentures~~ full set ( ) Cane ( ) Crutches ( ) Walker ( ) Wheelchair ( ) Braces ( ) Artificial Limb ( ) Other

8) Additional comments complaints symptoms: None ☑

S)

O) Fever Y (N) Swollen Glands Y (N) Signs of Infection Y (N) Skin Intact (Y) N

A)

P)

If known Diabetic * Call M.D. for order _____ **Initial Insulin given:** _____

I have answered all questions truthfully. I have been told and shown how to obtain medical services. I hereby give my consent for health services to be provided to me by and through PRISON HEALTH SERVICES.

Bonnie Cammon
Inmate's Signature/Date

Susie Williams RN
Health Provider Signature/Date

60412 AI

Hepatitis B Vaccine Consent Form

FACILITY NAME Easterling Correctional Facility

Lonnie Lammon — **Inmate Name**

238498 — **AIS Number**

Lonnie Lammon — **Inmate Signature**

12-22-05 — **Date**

Dose Given 20 mcg. (1 ml.) / 2nd dose

Site Given (R) deltoid

Administered by L/M Rayner RN

Lot Number and Expiration Date AHBVB004BA
Exp. 1/20/06

Hepatitis B Vaccine Consent Form

FACILITY NAME Easterling

DOB 2/20/78

Lonnie Cammon

Inmate Name **AIS Number**

237498 Lonnie Cammon 11-22-05

Inmate Signature **Date**

Dose Given 1 ml.

Site Given (L) deltoid

Administered by SMcKinnon LPN

Lot Number and Expiration Date Lot# AHBVB004BA
EXP. 01/20/2006

11/21/2005

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 6-13-06

To: DOC

From: HCU

Inmate Name: Cannon, Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

May use diapers prn x 30 days.
6/13/06 → 7/13/06

Date: 6/13/06 **MD Signature:** Dr Sidney N Smith **Time:** 1900

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 6/8/06

To: DOC / BCCF

From: HCU LPN

Inmate Name: Cannon, Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Hemorrhoidal Cream x 20 days KOP.

Ends 6/28/06

Date: 6/8/06 **MD Signature:** Dr Seddig / LPN **Time:** 9:25 Am

60418

ALABAMA DEPARTMENT OF CORRECTIONS

RECEIVING SCREENING FORM

Inmate's Name: Lonnie Cannon 3/238498 Date: 5/31/06 Time: _____

DOB: _____ Officer _____ Institution: BCCF

Booking Officer's Visual Opinion

		YES	NO
1.	Is the inmate conscious?	✓	
2.	Does the inmate have any obvious pain or bleeding/other symptoms suggesting the need for emergency services?		✓
3.	Are there any visible signs of trauma or illness requiring immediate emergency treatment or doctor's care?		✓
4.	Any obvious fever, swollen lymph nodes, jaundice, or other evidence of infection which might spread through the institution?		✓
5.	Is the skin in poor condition of show signs of vermin or rashes?		✓
6.	Does the inmate appear to be under the influence of alcohol or drugs?		✓
7.	Are there any visible signs of alcohol or drug withdrawl? (extreme perspiration, shakes, nausea, pinpoint pupils, etc.)		✓
8.	Is the inmate making any verbal treats to staff or other inmates?		✓
9.	Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	✓	
10.	Does the inmate have any obvious physical handicaps?	✓	

If the answer is YES to any questions from 2-10 above, specify WHY in section below.

11.	Are you presently taking medication for diabetes, heart disease, seizure, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder?	✓	
12.	Are you on any special diet prescribed by a physician? (If YES, what type?)		✓
13.	Do you have a history of venereal disease or abnormal discharge?		✓
14.	Have you recently been hospitalized or recently seen a medical or psychiatric doctor any illness?	✓	
15.	Have you ever attempted suicide?		✓

(If YES, When? _____ How? _____

16.	Do you want to do any harm to yourself now?		✓

	YES	NO	NO RESPONSE
17. Do you want to talk to a mental health counselor?			
18. Are you allergic to any medication?			
19. Have you recently fainted or had a head injury?			
20. Do you have epilepsy?			
21. Do you have a history of tuberculosis?			
22. Do you have diabetes?			
23. Do you have hepatitis?			
24. Do you have a painful dental problem?			
25. Do you have any medical problems we should know about?			
26. Do you have a past alcohol or drug history?			

What type? _____ How much used? _____

For how long? _____ Last time used? _____

Comments: (Unusual behavior, etc.)

_____

_____

_____

For the Officer:

27. Was the new inmate briefed on sick/dental call procedures? Yes

28. This inmate was:
   a. Released for normal processing Yes
   b. Referred to appropriate health care unit
   c. Immediately sent to health care unit

A. Tate
Officer's Signature

NOTE: This form is completed on inter and intra system transfers at receiving and will be filed in the inmates' medical jacket to comply with ACA Standards 2-4289, 2-4290 and AMA Standard 140.

K Lamar Common
Inmate's Signature

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 5/31/06

To: DOC

From: Infirmary

Inmate Name: Cannon, Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Lay in X 1 year

1 stop 5/31/07

Date: 5/31/06 **MD Signature:** pp Dr Eddy/mcs **Time:** 1530

60418

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 5-2-06

To: Doc

From: P/B

Inmate Name: Cannon Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in
2. Medical Isolation
3. Work restrictions
4. May have extra _______ until _______
5. Other

Comments:

elevate (L) arm X 3mo
May use laundry Bag
5-3-06 → 8-3-06

Date: 5-3-06 **MD Signature:** W. Darbouze/A **Time:** 9:00

60418

X Lonnie Cannon

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Cammon, Lonnie

Date of Birth: [redacted] Social Security No: _____

Date: 7/26/06 Time: 5:20 A.M. P.M.

This is to certify that I, Lonnie Cammon (Print Inmate's Name), currently in custody at the BCCF (Print Facility's Name), am refusing to accept the following treatment/recommendations: Sick Call (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Lonnie Cammon (Signature of Inmate)**

Dewanda Gipling LPN (Signature of Medical Person)

Hannah Johnson COI (Witness)

Gloria Rogers (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PHS
PRISON HEALTH SERVICES
INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Cammon, Lonnie # 238498

Date of Birth: [redacted] Social Security No.: _____

Date: 4-17-06 Time: 130 A.M. (P.M.)

This is to certify that I Lonnie Cammon (Print Inmate's Name), currently in custody at the ECF (Print Facility's Name), am refusing to accept the following treatment/recommendations: NO Show SICK Call 4-17-06 (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

X Lonnie Cammon
(Signature of Inmate)**

(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member

60115 (5/85)

PHS
PRISON
HEALTH
SERVICES
INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Lonnie Cammon

Date of Birth: [redacted] Social Security No.: [redacted]

Date: 4/12/06 Time: 7:09 A.M. ~~P.M.~~

This is to certify that I, Lonnie Cammon (Print Inmate's Name), currently in custody at the Easterling C.F. (Print Facility's Name), am refusing to accept the following treatment/recommendations: Dr. Darbouze appointment. (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare

x Lonnie Cammon 238498 (Signature of Inmate)** — M Payne RN (Signature of Medical Person)

[signature] (Witness) — (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member

60115 (5/85)

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 3/15/06

To: DOC

From: NCU

Inmate Name: Cannon Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Return on 3/17/06
@ 1030 am for PPD
reading —

Date: 3/15/06 **MD Signature:** Daubre MD **Time:** 1030

60418

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 3/9/06

To: Doc

From: PHS

Inmate Name: Cammon Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions X
4. May have extra _____ until _____
5. Other _____

Comments: Sling @ arm x 2 weeks 3/9/06 – 3/23/06
Lay-in profile x 6 months 3/9/06 – 9/9/06
Keep @ hand ↑ x 2 weeks 3/9/06 – 3/23/06.

Date: 3/9/06 **MD Signature:** VO Dr Darby **Time:** 12:50 pm

✓ Lonnie Cammie

60418

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

7B

Date: 3/13/06

To: DOC

From: PHS

Inmate Name: Cammon Lonnie ID#: 238498

The following action is recommended for medical reasons:

1. House in
2. Medical Isolation
3. Work restrictions
4. May have extra until
5. Other

Comments:
Allow pt to have Ace Wraps x 2.

Date: 3/13/06 MD Signature: [signature] Time: 10:30 AM

60418

X Lonnie Cammon

PHS
PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Cannon Lonnie 238498
(Print Name) (Doc#)

acknowledge receipt of the following medical equipment or appliance:

( ) Splint
( ) Eyeglasses
( ) Dentures
( ) Prothesis describe _____
( ) Wheelchair
( ) Cane
( ) Crutches
(X) Other describe Sling for arm (blue)

I acknowledge that the equipment/appliance is functional for my use

I also acknowledge the equipment/appliance is in good working condition.

X Lonnie Cannon 3/10/06
(Inmate) (Date)

M Payne RN 3/10/06
(Witness) (Date)

INMATE NAME (LAST FIRST MIDDLE)	DOC#	DOB	R/S	FAC
Cannon, Lonnie	238498	[redacted]	B/M	Easterling

PHS-MD-70005 (White – Medical File Yellow – Security Property Officer)

PHS
PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 3/9/06 TIME 1015 (AM) PM
ORIGINATING FACILITY East ☐ SIR ☐ PDL ☐ ESCAPEE ☐ ____
☐ SICK CALL ☐ EMERGENCY ☒ OUTPATIENT

ALLERGIES NKDA 141#
CONDITION ON ADMISSION ☒ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

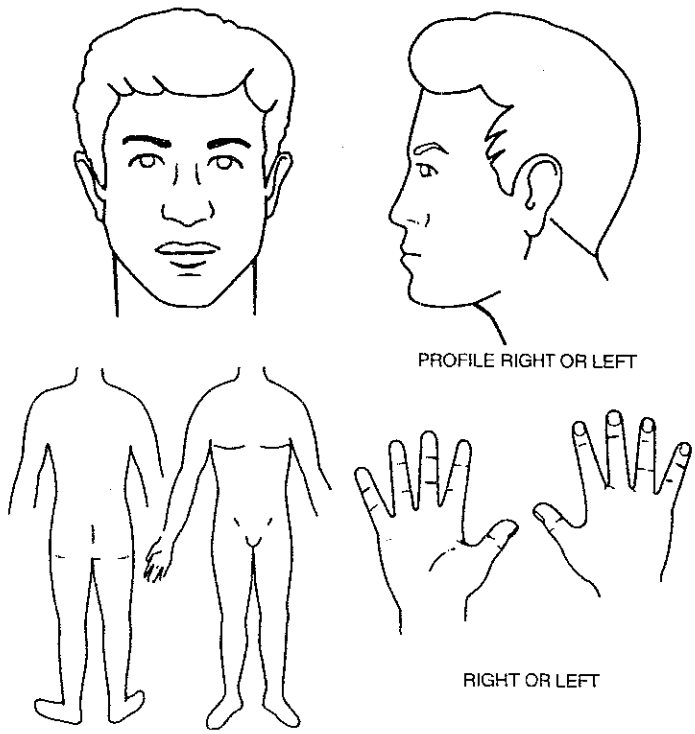
VITAL SIGNS: TEMP 98.8 (ORAL) RECTAL RESP 16 PULSE 64 B/P 134 80 RECHECK IF SYSTOLIC <100> 50 ____/____

NATURE OF INJURY OR ILLNESS

S To see the MD About my arm.

O- Edema noted to L arm. Skin warm & dry to the touch. Able to overcome gravity & ext NO broken areas or bruises noted to ext
A- alteration in tissue perfusion.
P- To see MD this AM

ABRASION ///	CONTUSION #	BURN xx xx	FRACTURE Z Z	LACERATION / ____ SUTURES



PHYSICAL EXAMINATION

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY

DIAGNOSIS

INSTRUCTIONS TO PATIENT

DISCHARGE DATE 3/9/06 TIME 1020 AM PM (RELEASE) / TRANSFERRED TO ☒ DOC ☐ AMBULANCE ☐
CONDITION ON DISCHARGE ☒ SATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL

NURSE'S SIGNATURE [signature] DATE PHYSICIAN'S SIGNATURE DATE CONSULTATION

INMATE NAME (LAST FIRST MIDDLE)	DOC#	DOB	R/S	FAC
Cannon Lonnie	238498	[redacted]	B/M	East

PHS

Nursing Evaluation Tool: General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Cammon (Last) Lonnie (First)

Inmate Number: 238498 Date of Birth: [redacted] (MM DD)

Date of Report: 2 / 26 / 06 (MM DD YYYY) Time Seen: 2:00 AM / PM Circle One

Subjective: Chief Complaint(s): My arm is hurting & I need my toe Nail taken off

Onset: X 2 mos

Brief History: My arm is still hurting & swollen.
(Continue on back if necessary)

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 98.2 P: 80 RR: 16 B/P: 134/76

Examination Findings: Edema Noted to L Left arm. Has difficulty moving arm. Fungus & thick Nail Noted to big toe @ Rt.
(Continue on back if necessary)

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s): Alleration in Comfort

☒ Referral NOT REQUIRED

☐ Referral REQUIRED due to the following: (Check all that apply)

☒ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other:

Dated 2/27/06

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.

☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe)

OTC Medications given ☒ NO ☐ YES (If Yes List):

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Date for referral: 3/31/06 (MM DD YYYY)

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

x T Mckinnon RN
Nurses Signature

Name: T Mckinnon
Printed

PHS
PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 2/16/06 TIME 9:25 AM (PM)
ORIGINATING FACILITY Easterling ☐ SIR ☐ PDL ☐ ESCAPEE ☐
☐ SICK CALL ☐ EMERGENCY ☐ OUTPATIENT

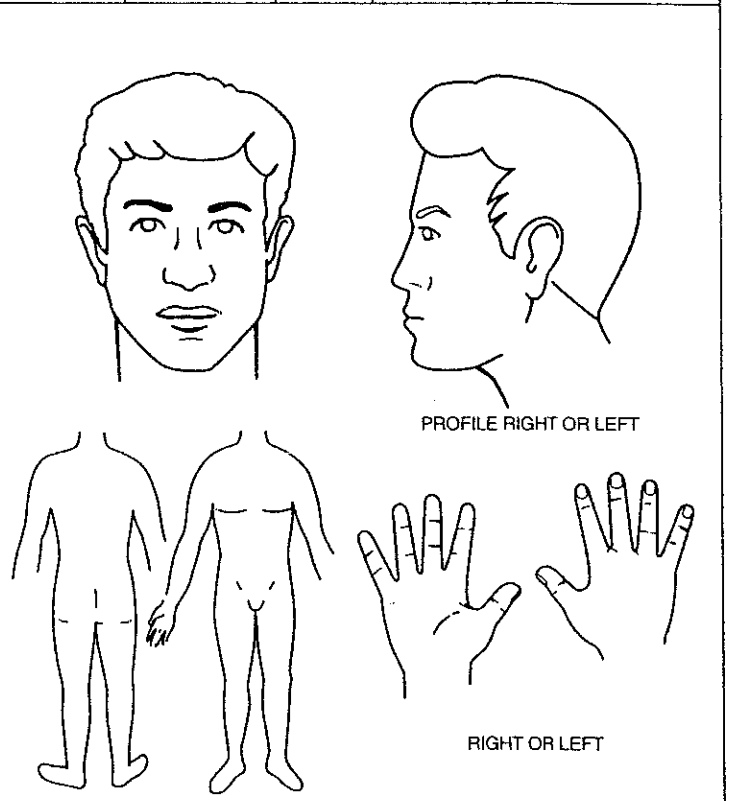
ALLERGIES NKA
CONDITION ON ADMISSION ☒ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 98.1 (ORAL) RECTAL O2 97% RESP 16 PULSE 71 B/P 110/70 RECHECK IF SYSTOLIC <100> 50 ___/___

NATURE OF INJURY OR ILLNESS

S- "Being swelling ever since I've been here."
O- B/M Ambulated to HCU E even steady gait. A+O X3. Skin W/D. Left hand + arm swollen. Chart shows that pt. was seen by Dr. Darbouze on 2-15-06 + was started on Naproxen 375mg Bid.
A- Alt. in Health Maintenance
P- Continue on medication as Prescribed. — M. Moate LPN

ABRASION ///	CONTUSION #	BURN xx xx	FRACTURE Z Z	LACERATION / ___ SUTURES



PHYSICAL EXAMINATION

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY

DIAGNOSIS

INSTRUCTIONS TO PATIENT
Continue to take medication + elevate arm

DISCHARGE DATE 2/16/06 TIME 9:35 AM (PM)
RELEASE / TRANSFERRED TO ☐ DOC ☐ AMBULANCE ☐
CONDITION ON DISCHARGE ☒ SATISFACTORY ☐ FAIR ☐ POOR ☐ CRITICAL

NURSE'S SIGNATURE M. Moate LPN DATE 2-16-06
PHYSICIAN'S SIGNATURE DATE 2/20/06
CONSULTATION

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC
Cammon, Lonnie	2384[redacted]		B/M	ECF

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 2-7-06

To: ADOC (Easterling)

From: PHS (Easterling)

Inmate Name: Cammon, Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in
2. Medical Isolation
3. Work restrictions
4. May have extra ______ until ______
5. Other BP + Pulse QD X 3days c SAR

Comments: 2/8/06 BP A P A
2/9/06 BP 130/80 P 72
2/10/06 BP 138/78 P 76
2/11-06 140/76 P 65

2/21/06

Date: 2/7/06 **MD Signature:** V.O. Dr. Darbo [signature] **Time:** 2

60418

X Lonnie Cammon

PHS
PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 1/24/06 TIME 1110 AM/PM
ORIGINATING FACILITY Easterling ☐ SIR ☐ PDL ☐ ESCAPEE ☐
☐ SICK CALL ☐ EMERGENCY ☒ OUTPATIENT

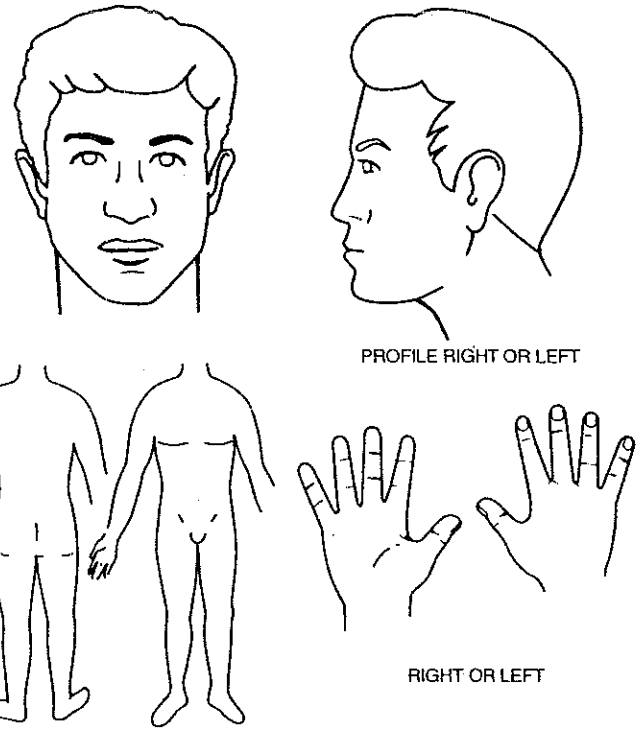
ALLERGIES NKDA wt. 140
CONDITION ON ADMISSION ☐ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 98 ORAL/RECTAL RESP 16 PULSE 88 B/P 102/60 RECHECK IF SYSTOLIC <100> 50 /

NATURE OF INJURY OR ILLNESS
S-"My left side is hurt + swollen, H/A

O2Sat- 93%

ABRASION /// CONTUSION # BURN xx xx FRACTURE Z Z LACERATION / ____ SUTURES



PHYSICAL EXAMINATION
O- Blm Amb. to NCU c steady gait A+Ox3 Resp c ease Skin WD c/o pain to (L) arm swelling noted & discoloration or deformity noted.

A- Alt. in comfort

P- To see MD for eval.

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY

DIAGNOSIS

INSTRUCTIONS TO PATIENT

DISCHARGE DATE 1/24/06 TIME AM/PM
RELEASE / TRANSFERRED TO ☐ DOC ☐ AMBULANCE ☐
CONDITION ON DISCHARGE ☐ SATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL

NURSE'S SIGNATURE SBushnell DATE 1/24/06
PHYSICIAN'S SIGNATURE [signature] DATE 1/24/06
CONSULTATION

INMATE NAME (LAST FIRST MIDDLE) Camman Lonnie
DOC# 238498 [redacted] DOB R/S Blm FAC ECF

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Lonnie Cammon

Date of Birth: [redacted] Social Security No: _____

Date: 1-23-2006 Time: 8:00 A.M. (P.M.)

This is to certify that I, Lonnie Cammon (Print Inmate's Name), currently in custody at the [illegible] (Print Facility's Name), am refusing to accept the following treatment/recommendations: S/C 1-23-2006 (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare

Lonnie Cammon (Signature of Inmate)** [illegible] (Signature of Medical Person)

_____ (Witness) _____ (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 1-23-06

To: Dr.

From: PHS

Inmate Name: Cannon Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other BP & Pulse ✓ every day X3 days 5Am & hour

Comments:

1-24 BP 120/64 P 74

1-25 BP 110/60 P 100

1-26 BP 122/70 P 68

Date: 1-23-06 **MD Signature:** VO Dr Barbee/fm **Time:** 9:00 Am

60418

Lonnie Cannon

9/8/00

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Cammun, Lonnie

Date of Birth: 2-2-28 Social Security No.: 238498

Date: 12/4/05 Time: 7 A.M. ~~P.M.~~

This is to certify that I, Lonnie Cammon (Print Inmate's Name), currently in custody at the Easterling (Print Facility's Name), am refusing to accept the following treatment/recommendations: NO Show for Sick call (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare

Lonnie Cammon
(Signature of Inmate)**

CWamclerk LPN
(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member

60115 (5/85)

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 11/29/05

To: DOC

From: HCU

Inmate Name: Cannon Lonnie **ID#:** 238198

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

May have Walking Cane to keep on person

Date: 11/29/05 **MD Signature:** Dawson / SB **Time:** 730 a

60418

Lonnie Cannon

DEPARTMENT OF CORRECTIONS

EMERGENCY/(OTHER) TREATMENT RECORD

DATE 11-19-05 TIME 455 AM/PM

FACILITY Easterling ☐ SIR ☐ PDL ☐ ESCAPEE ☐

☐ EMERGENCY ☐ OTHER

ALLERGIES NKA

CONDITION ON ADMISSION ☐ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 97 z. ORAL / RECTAL RESP 18 PULSE 77 B/P 160/86 RECHECK IF SYSTOLIC <100> 50

NATURE OF INJURY OR ILLNESS

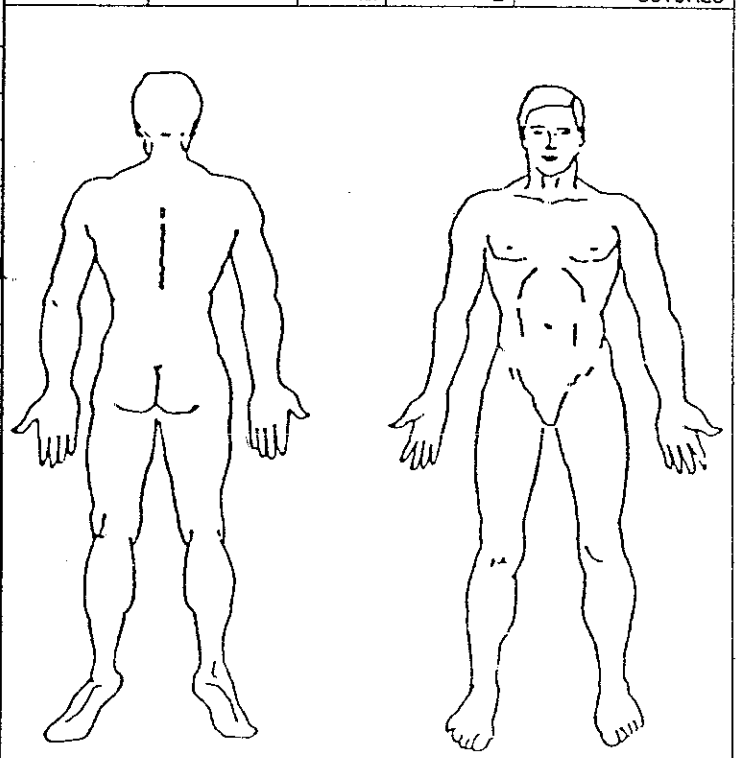
S: "I fell stepping up on the porch at the gym. I didnt step up high enough"

O: B/m to HCU via wheelchair. A&Ox3. Resp even et unlabored Skin warm et dry to touch. C/o pain ® Knee. Reddened area noted to medial aspect of ® Knee. Mild swelling noted. & deformity noted. Partial weight bearing at this time

A: DOC Body Chart

PHYSICAL EXAMINATION

ABRASION///	CONTUSION #	BURN xx xx	FRACTURE Z Z	LACERATION/ SUTURES



ORDERS MEDICATION, etc

P. Apply ice to ® Knee and elevate. Hold in infirmary for observation. Motrin 400mg po bid x 3 days.

510 am - Ambulated in ER. States "it doesn't hurt like it did I think I'll be ok"

DIAGNOSIS

INSTRUCTIONS TO PATIENT

RELEASE/TRANSFER DATE	TIME	RELEASE/TRANSFERRED TO	CONDITION ON DISCHARGE
11/19/05	510 AM/PM	☐ DOC ☐ AMBULANCE Infirmary for observation	☐ SATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL

NURSE'S SIGNATURE	DATE	PHYSICIAN'S SIGNATURE	DATE	CONSULTATION
J Hawkins LPN	11-19-05		11/21/05	

PATIENT'S NAME (LAST FIRST MIDDLE)	AGE	DATE OF BIRTH	R/S	AIS #
Cammon, Lonnie	77	[redacted]	B/m	238498

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Cammon, Lonnie

Date of Birth: [redacted] Social Security No.: 238498

Date: 11-19-05 Time: 520 A.M. P.M.

This is to certify that I Cammon, Lonnie (Print Inmate's Name), currently in custody at the ECF (Print Facility's Name), am refusing to accept the following treatment/recommendations: Refused to Stay in infirmary for Observation (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare

Lonnie Cammon
(Signature of Inmate)**

Hawkins Lpn.
(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

JB60

PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Lonnie Cammon

Date of Birth: _____ Social Security No: _____

Date: 10-12-05 Time: 11:00 A.M. P.M.

This is to certify that I, _____ (Print Inmate's Name), currently in

custody at the Easterling Corr. Facility (Print Facility's Name), am refusing to

accept the following treatment/recommendations: MD Appt (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which may result from this action/refusal and I personally assume all responsibility for my welfare

Lonnie Cammon 238498 (Signature of Inmate)** J McKinnon LPN (Signature of Medical Person)

_____ (Witness) _____ (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PHS

Nursing Evaluation Tool: Chest Pain

Facility: Easterling

Patient Name: Cammon (Last) Lonnie (First)

Inmate Number: 238498 Date of Birth: [redacted]

Date of Report: 10 / 05 / 2005 (MM DD YYYY) Time Seen: 6:35 AM / PM Circle One

Subjective Chief Complaint(s): "I hurt under both arms into my arm & whatever

Onset: 1 yr Activity prior to onset: None

History: Pt States they won't let me have my Caratab any more. It takes care of all my pain "Hurts some right here." legs
(Continue on back if necessary)

Description of Pain: ☐ Burning ☐ Stabbing ☐ Dull/Achy ☐ Pressure-like ☐ Crushing ☑ Other: Pt States all the time ☐ Check Here if additional notes on back

Duration of Pain: All the time Does anything relieve the pain? Caratab

Onset of Pain: ☐ New onset ☐ Sudden ☐ Gradual ☑ Chronic Pain Scale: (1-10) States "I don't know" History of injury? ☐ YES ☑ NO

Radiation: ☐ No radiation ☐ Radiation to:

Aggravating Factors: ☐ Exertion ☐ Stress ☐ Food intake ☐ Movement ☐ Coughing ☑ Other: Requests Caratab

Associated Symptoms: ☐ Nausea/Vomiting ☐ Diaphoresis ☐ Dyspnea ☐ Syncope ☐ Cough ☐ Sputum production ☐ Hemoptysis ☐ Fever ☐ Chills

Cardiac Risk Factors: ☐ Family history ☐ Smoke:___ppd/___ years ☐ Hypertension ☐ Diabetes ☐ Hyperlipidemia ☐ CAD

History of: ☐ Peptic ulcer ☐ Illicit drug use ☐ Cardiac disease ☐ Nitroglycerin use

Objective: Vital Signs: (As Indicated) T: 98.8 P: 61 RR: 18 B/P: 138 / 94 O2 Sat 97%

Pulse Ox %: 97 % ☑ Room Air ☐ O2 LPM:

General Appearance: ☑ No acute distress ☑ Alert ☑ Oriented x 3 ☐ Anxious ☐ Acute distress

Color: ☑ Normal ☐ Pale ☐ Flushed ☐ Cyanotic ☐ Jaundiced

Skin: ☑ Warm ☐ Dry ☐ Cool ☐ Moist/Clammy

EKG ordered? ☐ YES ☐ NO — Done - gr

EKG interpretation / computer read or available for physician? ☑ YES ☐ NO

Lung sounds:

Right		Left
☑	Clear	☑
☐	Diminished	☐
☐	Crackles	☐
☐	Rhonchi	☐
☐	Wheezing	☐

☑ Additional Examination: No SOB, Cyanosis or N&V Noted. Pt Shows no visible distress noted. Pt States it hurts "Some in my chest"
(Continue on back if necessary) ☐ Check Here if continued on back

Assessment: (Referral Status) Preliminary Determination(s): Alt in Comfort R/T C/O

☑ Referral NOT Required

☐ Referral Required due to the following: (Check all that apply)

☐ Acute distress ☐ Abnormal vital signs ☑ Recurrent Complaint (More than 2 visits for same complaint)

☐ Cardiac history ☐ Suspicious cardiac symptomology ☐ Cardiac Risk Factor present

☐ History of recent illicit drug use ☑ Other: Pt Signed a Waiver

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given

Plan: Check All That Apply: *Acute distress* – arrange for immediate emergency transport

☐ Administer oxygen if in acute distress ☐ ASA _____mg po

☑ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☑ Instructions to return if condition worsens

☑ Other: Pt Signed a Waiver Refused to Wait for orders from MD (Describe)

OTC Medications given ☐ NO ☑ YES (If Yes List): Advil Given Now

Referral: ☑ NO ☑ YES (If Yes, Whom/Where): Dr Darbouze Date for referral: 10 / 06 / 05 (MM DD YYYY) Noted 10/6/05

Referral Type: ☑ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____ Time _____

x [signature] Nurses Signature Name: D Sheehan LPN (Printed)

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: CAMMON Connie

Date of Birth: [redacted] Social Security No: 238498

Date: 10/05/05 Time: 735 A.M. P.M.

This is to certify that I, CAMMON Connie (Print Inmate's Name), currently in custody at the CASterbs (Print Facility's Name), am refusing to accept the following treatment/recommendations: to Stay Until MD Calls back about Body Chart + EKG per C/o Chest discomfort (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

X Lonnie Cammon
(Signature of Inmate)**

(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Lonnie Cammon 238498

Date of Birth: [redacted] Social Security No: _____

Date: 9-9-05 Time: _____ A.M. P.M.

This is to certify that I, Lonnie Cammon (Print Inmate's Name), currently in custody at the Easterling (Print Facility's Name), am refusing to accept the following treatment/recommendations: SLK (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ill effects which, may result from this action/refusal and I personally assume all responsibility for my welfare.

Lonnie Cammon 238498 (Signature of Inmate)** _____ (Signature of Medical Person)

_____ (Witness) _____ (Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

60115 (5/85)

PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

KITCHEN CLEARANCE PHYSICAL ASSESMENT

	YES	NO
ANY OPEN SORES OR RASHES ON HANDS, ARMS, FACE & NECK	___	X
TB TEST CURRENT	X	___
DOES PT. SHOW ANY OBVIOUS SIGNS OF ANY OTHER DISEASE	___	X

OTHER: _____

THIS PATIENT HAS BEEN INFORMED OF THE NEED FOR THE FOLLOWING:

PROPER HANDWASHING, NOT TO HANDLE FOOD WHILE SICK, SEEK MEDICAL EVALUATION WHEN NECESSARY AND TO NOTIFY THE DIETARY SERVICES SHIFT SUPERVISOR OF ANY ILLNESS.

MEDICAL AUTHORITY: Gallemore, lpn DATE: 8-22-05

I attest that the above statement is true to the best of my knowledge
PATIENT SIGNATURE: Lonnie Cannon DATE: 8-22-05

EXPIRATION DATE: None

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	Race/Sex	FAC.
Cannon Lonnie	238-198	[redacted]	M	ETS

EAS[illegible]RLING CORRECTIONAL FACIL
PROC[illegible]DURE FOR ACCESS TO HEALTH CARE

ACCESS TO HEALTHCARE: All inmates have access to healthcare 24 hours a day, 7 days a week.

SICK CALL SCREENING: Treatment for routine medical, dental and mental health complaints are processed through nurse screening seven days a week. You must complete a sick-call screening form and turn this form into medical services for processing. You may obtain screening forms from any dorm cube or shift commander's office. You need to place the screening form in the locked box located at the dining hall. Sick Call forms for Segregation will be picked up by the nurse on the 4:00am medication rounds. Sick Call Screening for population is held Sunday through Friday on second shift at 7:30pm. Segregation Sick Call Screening is held during the 9:00pm pill call. Doctor's clinic is held Monday through Friday excluding holidays or an unexpected emergency.

FEE FOR SERVICE: All health service requests are subject to a $3.00 co-pay that will be deducted from your PMOD account by The Department of Corrections, depending on the nature of your request. Prison Health Services does not receive the monies collected from the co-pay. Please realize that no one is denied care based on their inability to pay for services.

NOTIFICATION OF SCHEDULED APPOINTMENTS: All scheduled appointments are placed in the inmate news letter on a daily basis. It is your responsibility to check the newsletter on a daily basis. If you fail to appear for any scheduled appointment, you will be required to sign a Release of Responsibility.

PILL CALL TIMES:

POPULATION	DIABETIC	SEGREGATION
4:00am	3:00am	4:00am
9:00am	9:00am	10:00am
5:00pm	3:00pm	5:00pm

MEDCIAL EMERGENCIES: Medical request on weekends and holidays are reviewed. Any request for medical attention that cannot wait until the next sick-call clinic will be processed at that time. All other request will be held until regular Sunday through Friday sick call. Medical emergencies, such as those involving intense pain, potential life-threatening situations, or when delaying treatment might cause permanent damage are dealt with at any time. Advise the nearest Correctional Officer of an emergency, so prompt access to health care is provided.

DENTAL SICK CALL: You are required to sign up for Dental sick call using the same procedure as medical sick call. There is a $3.00 co-pay for dental screening. There is no charge for follow up care scheduled through dental screening. Population and Segregation Dental Screenings are held during sick call screenings at 7:30pm in the Health Care Unit. Follow-up care, if needed, is scheduled at this time. Emergency dental service is provided 24 hours a day with a dentist on call. Those not meeting scheduled appointments must sign a refusal of treatment form.

ACCESS TO MENTAL HEALTH TREATMENT: You can access mental health by filling out a sick call form and coming to sick call. There is no co-pay for mental health services. If you have a mental health emergency you should notify the nearest Correctional Officer so that prompt access is provided.

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 6-13-05

To: ADOC

From: WW NSG.

Inmate Name: Cammon, Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Came to West Ward to get Eye drops @ 8$^{00}_{A}$ & 8$^{00}_{PM}$ Every day

Date: 6/13/05 **MD Signature:** V.D.R. Robbins/R Frank LPN **Time:** 0900

60418

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 4-5-05

To: DOC

From: OPC

Inmate Name: Cammon, Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Medica Hold until AFTER last inj.

Report to OPC 4-13-05 & 4-20-05

Date: 4-5-05 **MD Signature:** UO M. Webb CNP/ Graves **Time:** _____

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

W 22

Date: 4/01/05

To: ADOC

From: PHS-Dr. Bradford, Eye Doctor

Inmate Name: Cannon, Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Go to West Ward at 9 am and 4 PM everday to have your eye drops put instilled.

Date: 04/01/05 **MD Signature:** Dr. Bradford Linda Bell **Time:** 1510

60418

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 3-17-05

To:

From:

Inmate Name: Cammon, Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in
2. Medical Isolation
3. Work restrictions
4. May have extra ______ until ______
5. Other Bottom Bunk x 180 days

Comments:

Date: 3-17-05 **MD Signature:** M Webb CRNP/ **Time:**

[illegible]

60418

RECEIVING SCREENING FORM

INMATE'S NAME: Cammon, Lonnie DATE: 3/16/05 TIME: 8:45AM

DOB: [redacted] OFFICER: Darrell Mears INSTITUTION: KILBY

RECEIVING OFFICER'S VISUAL OPINION

	YES	NO
Is the inmate conscious?	X	
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?		
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?		
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?		
Is the skin in poor condition or show signs of vermin or rashes?		
Does the inmate appear to be under the influence of alcohol, or drugs?		
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc)		
Is the inmate making any verbal threats to staff or other inmates?		
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?		
Does the inmate have any obvious physical handicaps?		

FOR THE OFFICER

Was the new inmate oriented on sick/dental call procedures?

This inmate was
- X a Released for normal processing
- _____ b Referred to health care unit
- _____ c Immediately sent to the health care unit

Darrell Mears
Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards.

EXHIBIT
Blumberg No. 5118
A-5

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: D.O.B. / / ALLERGIES: Use Last Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Fourth Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Third Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Second Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Cammon [illegible] 238498 D.O.B. [redacted] 9/11/06 ALLERGIES: Use First Date 9/11/06	DIAGNOSIS [illegible] tab i [illegible] x 15 days PO [illegible] ☐ GENERIC SUBSTITUTION IS NOT PERMITTED

110 (4/03)

MEDICAL RECORDS COPY

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Cannon, Lonnie #238498

D.O.B. [redacted]

ALLERGIES: NKDA

Use Last Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cannon, Lonnie #238498

D.O.B. [redacted]

ALLERGIES: NKDA

Use Fourth Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cannon, Lonnie #238498

D.O.B. [redacted]

ALLERGIES: NKDA

10/10/06

Use Third Date / /

DIAGNOSIS (If Chg'd)

Dexicidue Eyedrops
Ibuprofen 600 po bid x (10)

noted 10/10/06

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Common Lonnie

D.O.B. /

ALLERGIES:

9/26/06

Use Second Date 9/26/06

DIAGNOSIS (If Chg'd)

Key Lock profile x 6 months
T.O. Dr Sidley / M. Jackson

M. Jackson 9-26-06

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Cannon, L.

D.O.B. / / 238498

ALLERGIES:

noted 9/21/06

Use First Date / /

DIAGNOSIS

Naprosyn 375 po bid x (10)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

9/21/06

MEDICAL RECORDS COPY

60110 (4/03)

PHS
PRISON HEALTH SERVICES INCORPORATED

Carrion, Connie

PROGRESS NOTES

Date/Time	Inmate's Name: D.O.B.: / /
9/7/6	S) arthritis
	O) (B) Elbow arthritis
	Back pain
	He refuses to take his meds
	and meds
	A) arthritis
	P) will give naprosyn 500
10/10/06	S) (R) eye redness
	O) mild conjunctivitis
	A/P) will give neomycin eye drops

60111 (5/85)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 10-10-06
ID # 238498 Date of Birth: [redacted] Location: 16/02
Nature of problem or request: Need to see Eye doctor
Something is Growing on my Eye
thank you
Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: _____ **P:** _____ **R:** _____ **BP:** _____ **WT:** _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

CLF 1002 (1/1)

PHS

Nursing Evaluation Tool: General Sick Call

Facility: BBB

Patient Name: Crawford Lonnie (Last, First, MI)

Inmate Number: 238498

Date of Birth: [redacted] (MM DD YYYY)

Date of Report: 9 / 21 / 06 (MM DD YYYY)

Time Seen: _____ AM / PM Circle One

Subjective: Chief Complaint(s): arthritis pain getting worse

Onset: cont problem

Brief History: (Continue on back if necessary) Chronic problem & arthritis

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: _____ P: 63 RR: 18 B/P: 138 / 72 98%

Examination Findings: (Continue on back if necessary) No apparent external findings @ present pain 1-9

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s): _____

☐ Referral NOT REQUIRED

☑ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: _____ (Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List): _____

Referral: ☐ NO ☐ YES (If Yes, Whom/Where): Gastro Date for referral: 9 / 21 / 06 (MM DD YYYY)

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____ Time _____

x _____ Name: K Walker LPN

PHS PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammon Date of Request: 9-21-06
ID # 238498 Date of Birth: [redacted] Location: 16-1
Nature of problem or request: I Need A No standing profile
I can't stand in that long line
Lonnie Cammon
Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: ____________ AM PM
Allergies: ______________

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective **(V/S): T:** ______ **P:** ______ **R:** ______ **BP:** ______ **WT:** ______

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cammack Date of Request: 9-20-06
ID # ~~23~~ 238498 Date of Birth: [redacted] Location: 16-2-06
Nature of problem or request: My Arthritis is bothering me. I sign up a week ago & I was suppose to be getting some Medicine 2 week's ago. But my medicine has not been there when I come to get call

Lonnie Cammack
Signature

DO NOT WRITE BELOW THIS LINE

Date: 9/21/06
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: 134 1/2

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

K Walker See Next Page
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Lonnie Cannon Date [redacted]uest: 7-24-06
ID # 238498 Date of Birth: [redacted] Location: 6-24
Nature of problem or request: Can't flush Water or Urine!

Lonnie Cannon
Signature

DO NOT WRITE BELOW THIS LINE

Date: ____/____/____
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: _____ **P:** _____ **R:** _____ **BP:** _____ **WT:** _____

(A)ssessment: Water Signed 7/26/06

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Facility Name:

Month/Year of Charting: 9/06

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Naprosyn 375mg ÷ PO tid	0400																					>	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	N79		
	1100																				>	9	9	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		<
	1700																				>	[illegible]	[illegible]	9	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	9	<

Start Date: 9/21/06 Prescriber: Siddiq

Stop Date: 10/01/06 RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Medication	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Start Date: Prescriber:

Stop Date: RX #:

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
	Robin Long	RL	Mary Young	MC	1. Discontinued Order
Allergies			Martha Jackson LPN	MJ	2. Refused
					3. Patient out of facility
					4. Charted in Error
Housing Unit:					5. Lock Down
Patient ID Number: 238498					6. Self Administered
Patient Name:					7. Medication out of Stock
Cannon / [illegible]			Date of Birth:		8. Medication Held
					9. No Show
					10. Other

Facility Name: Bullock Correctional Facility — Month/Year of Charting: 08/06

Hour: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Mevacor 40MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

See New Order Below

Start Date: 05-09-2006 — Prescriber: Darbouze, Jean
Stop Date: 08-06-2006 — RX #: 251492214

Aspirin EC 325MG EC Tab 30.00

Take 1 tablet(s) by mouth daily

1100 See New Order Below

Start Date: 05-09-2006 — Prescriber: Darbouze, Jean
Stop Date: 08-06-2006 — RX #: 251492217

NitroQuick 0.4MG SL Tab (Bottle) 1

Dissolve one tablet under tongue as needed

K D/C Reorder

Start Date: 05-09-2006 — Prescriber: Darbouze, Jean
Stop Date: 08-06-2006 — RX #: 251492225

Ditropan 5MG Tab 60.00

Take 1 tablet(s) by mouth twice daily

D/C

Start Date: 05-09-2006 — Prescriber: Darbouze, Jean
Stop Date: 08-06-2006 — RX #: 251492231

Naprosyn 250MG Tab 45.00

Take 1 tablet(s) by mouth Three Times Daily

0400 q
1100 q
1700 q

Start Date: 07-18-2006 — Prescriber: Siddiq, Tahir
Stop Date: 08-01-2006 — RX #: 251737036

Mevacor 20mg PO QD x180days

1700 q q q q q q q q q q q q q q q q q q q q q q q q q q q q q q

Start Date: 6/2/06 — Prescriber: Siddiq
Stop Date: 12/2/06 — RX #:

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial
	J Gipling LPN	JG	Martha Jackson LPN	MJ
Allergies				

Housing Unit: Population
Patient ID Number: 238498
Patient Name: **Cammon, Lonnie**
Date of Birth: [redacted]

Documentation Codes
1. Discontinued Order
2. Refused
3. Patient out of facility
4. Charted in Error
5. Lock Down
6. Self Administered
7. Medication out of Stock
8. Medication Held
9. No Show
10. Other

Facility Name: BCCF

Month/Year of Charting: 8/06

ASA 325mg PO QD x 180days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1100	9	9	9	9	9	9	5	9	9	5	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9

Start Date: 6/2/06 Prescriber: Siddiq

Stop Date: 12/2/06 RX #:

Start Date: Prescriber:

Stop Date: RX #:

Start Date: Prescriber:

Stop Date: RX #:

Start Date: Prescriber:

Stop Date: RX #:

Start Date: Prescriber:

Stop Date: RX #:

Start Date: Prescriber:

Stop Date: RX #:

Diagnosis	Nurse's Signature	Initial	Nurse's Signature	Initial	Documentation Codes
	Kipling LPN	TA			1. Discontinued Order
Allergies NKDA					2. Refused
					3. Patient out of facility
					4. Charted in Error
Housing Unit:					5. Lock Down
Patient ID Number: 238498					6. Self Administered
Patient Name:					7. Medication out of Stock
					8. Medication Held
					9. No Show
			Date of Birth:		10. Other

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 9/11/06 Time: 1510 Facility: Bcf

Check all applicable CIC's being evaluated: __Card/HTN __DM__GI__ID__PUL__SZ__TB

SUBJECTIVE: (R) forearm swelling

OBJECTIVE: BP 110/60 HR 73 RR 20 Temp 97 Wt 135 Peak Flow___

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities,; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

[illegible] [illegible] (R) forearm swelling 2° elbow [illegible]

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
Status: I=Improved, S=Stable, W=Worsened

DM			HTN/CARD			SZ			PUL			ID			GI			OTHER		
Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Contr		
G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P
Status			Status			Status			Status			Status			Status			Status		
I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W

PLAN: continue meds and [illegible]

F/U: Routine 90 days:______Other ______ Problem List Updated: Yes No

[illegible] [illegible]

______________________ 9/11/06
Physician/NP/PA

Cannon, Lonnie
NAME

238498
AIS#

M
GENDER

B
RACE

[redacted]
DOB

(Revised 5/18/05)

DEPARTMENT OF CORRECTIC

NURSE'S

CVHTN CHRONIC CARE CLINIC

S: CHRONIC CARE CLINIC DATE/TIME 9/11/06			ALLERGIES NKA
O: VS T 97 P 73 R 20 WT 135			HX a treadmill? Y (N)
BP 110/60 IF BP > 140/90 REFER TO MD/NP/PA			Date:
Do you smoke?	Y	(N)	HX bypass surgery: Y (N)
Use salt?	Y	(N)	Date:
Family History of CVHTN?	(Y)	N	
Obese?	Y	(N)	
Stress?	Y	(N)	
Blurred vision	Y	(N)	
Headache	Y	(N)	
Fatigue	(Y)	N	
Muscle weakness	(Y)	N	
Polyuria	(Y)	N	
Epistaxis	Y	(N)	P: LABS REVIEWED
S.O.B.	(Y)	N	Labs ordered
Compliant with meds	Y	(N)	Last CMP-14
KOP	Y	N	Last EKG
Counseled on risk factors	(Y)	N	
Describe:			
Labs/EKG WNL NA	Y	(N)	
CXR if over 50			
Education Done	(Y)	N	
Topic: Possible Heart attack & CVA			
Recently admitted to hospital/infirmary	Y	(N)	CURRENT MEDICATIONS:
Notes: c̄ Instructed on the need to comply c̄ medications as ordered			Mevacor 20 mg q[illegible] ASA - p o q[illegible]
			Status: (circle) IMPROVED (UNCHANGED) WORS[E]
			Level of Control: (circle) ~~GOOD~~ (FAIR) POOR
			CCC WITH NURSE (circle) 1, 2, (3) Months
			CCC WITH MD (circle) 1, 2, (3) 4, 5, 6 Months

INMATE NAME	NUMBER	AGE	RACE/SEX	SIGNATURE:
Cannon	238418	78	B M	[signature]

Control Good—BP < 140/90
Fair—BP 140-160/90/100
Poor—BP > 160/100

Status: Improved—BP< previous visit
Unchanged—BP unchanged
Worsened—BP increased

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 10/10/06

To: Doc

From: HCU

Inmate Name: Cannon, Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

1. House in
2. Medical Isolation
3. ~~Work restrictions~~
4. May have extra ______ until ______
5. Other

Comments:

Dexadene eye drops x 20 days
10/30/06

Date: 10/10/06 **MD Signature:** Dr Siddiq / Y Moseley LPN **Time:** 0900

60418

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 9-26-06

To: Inmate

From: Medical

Inmate Name: Cannon Lonnie **ID#:** 238498

The following action is recommended for medical reasons:

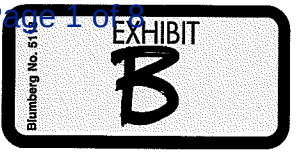
1. House in ______
2. Medical Isolation ______
3. Work restrictions ______
4. May have extra ______ until ______
5. Other ______

Comments:

Key lock profile X 6 Months
9-26-06 3-26-07

Date: 9-26-06 **MD Signature:** Dr Siddiq /m Jackson **Time:** 0600

60418



IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA

LONNIE CAMMON, (AIS #236498), *

*

Plaintiff,

*

V. 2:06-cv-674-WKW

*

DOCTOR SEDIET
and PRISON HEALTH SERVICES,

*

Defendants.

*

AFFIDAVIT OF TAHIR SIDDIQ, M.D.

BEFORE ME, _____, a notary public in and for said County and State, personally appeared **TAHIR SIDDIQ, M.D.**, and being duly sworn, deposed and says on oath that the averments contained in the foregoing are true to the best of his ability, information, knowledge and belief, as follows:

"My name is Tahir Siddiq. I am a medical doctor and am over twenty-one years of age. I am personally familiar with all of the facts set forth in this affidavit. I have been licensed as a physician in Alabama since 1996, and have been board certified in internal medicine since 1996. I have served as the Medical Director for Bullock Correctional Facility in Union Springs, Alabama, since 1997. Since November 3, 2003, my employment at Bullock County Correctional Facility has been with Prison Health Services, Inc. ("PHS"), the company which currently contracts with the Alabama Department of Corrections to provide medical services to inmates.

Lonnie Cammon (AIS #236498) is a 76 year old inmate who is currently incarcerated at Bullock County Correctional Facility. Mr. Cammon was transferred to Bullock from Easterling Correctional Facility on May 31, 2006. I am familiar with Mr. Cammon and have been involved with the medical services provided to him at Easterling. In addition, I have reviewed Mr. Cammon's Complaint in this action as well as his medical records (certified copies of which are being produced to the Court along with this Affidavit).

It is my understanding that Mr. Cammon has filed a Complaint in this matter alleging that I failed to provide him with appropriate medical care on August 5, 2006 and August 11, 2006. Mr. Cammon does not, however, specify how I have failed to treat him appropriately. He also states that that I have acted inappropriately in failing to refer him specialty evaluation. Mr. Cammon's allegations are completely unfounded.

As discussed above, Mr. Cammon was transferred to Bullock on May 31, 2006. I evaluated Mr. Cammon on June 1, 2006 for complaints of swelling in the left arm. I provided Mr. Cammon with a physical evaluation and determined that he had swelling of the left elbow with tenderness. He exhibited strong pulses. I prescribed him a Decadron (corticosteroid) injection to combat swelling. He was prescribed Naproxen for pain.

On June 2, 2006 fluid was taken from Mr. Cammon's elbow. It was determined that he did not suffer from gout. On July 10, 2006, I again evaluated Mr. Cammon and determined that his swelling was greatly reduced. He exhibited good range of motion. On July 17, 2006, Mr. Cammon presented again with swelling in the forearm. I started Mr. Cammon on prednisone.

Contrary to the allegations in his Complaint, Mr. Cammon did not present to the healthcare unit for treatment on either August 5, 2006 or August 11, 2006. In fact, he did not present for treatment at all during the month of August 2006. He presented to the healthcare unit again on September 11, 2006 with renewed complaints for elbow and back pain. He refused further treatment at that time. Specialty evaluation is not medically indicated for Mr. Cammon's treatment.

Based on my review of Mr. Cammon's medical records, and on my personal knowledge of the treatment provided to him, it is my medical opinion that all of his medical conditions and complaints have been evaluated in a timely fashion at Bullock Correctional facility, and that his diagnosed conditions have been treated in a timely and appropriate fashion. At all times, he has received appropriate medical treatment for his health conditions at Bullock. At no time has he been denied any needed medical treatment. In other words, it is my opinion that the appropriate standard of care has been adhered to at all times in providing medical care, evaluation, and treatment to this inmate. At no time have I, or any of the medical or nursing staff at Bullock Correctional Facility, denied Mr. Cammon any needed medical treatment, nor have we ever acted with deliberate indifference to any serious medical need of Mr. Cammon. At all times, Mr. Cammon's known medical complaints and conditions have been addressed as promptly as possible under the circumstances."

Further affiant sayith not.

TAHIR SIDDIQ, M.D.

10/26/6

STATE OF ALABAMA)

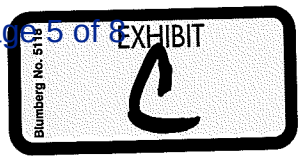
COUNTY OF)

I, Cynthia Rivers, a Notary Public in and for said State and County, hereby certify that TAHIR SIDDIQ, M.D. who being known to me and who being duly sworn, and whose name is signed to the foregoing document, acknowledged before me on this date that being first informed of the contents of said document, having read the same, and understanding its purpose and effect, voluntarily executed the same upon the above-stated date.

SWORN TO and SUBSCRIBED BEFORE ME on this the 26th day of October, 2006.

Cynthia Rivers
NOTARY PUBLIC
My Commission Expires: 7/15/10

(NOTARIAL SEAL)



IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA

LONNIE CAMMON, (AIS #236498),	*	
	*	
Plaintiff,	*	
V.	*	2:06-cv-674-WKW
DOCTOR SEDIET and PRISON HEALTH SERVICES,	*	
Defendants.	*	

AFFIDAVIT OF KAY WILSON, R.N., H.S.A.

BEFORE ME, Grace M. Maloy, a notary public in and for said County and State, personally appeared **KAY WILSON, R.N., H.S.A.**, and being duly sworn, deposed and says on oath that the averments contained in the foregoing are true to the best of her ability, information, knowledge and belief, as follows:

"My name is Kay Wilson. I am over the age of twenty-one and am personally familiar with all of the facts set forth in this Affidavit. I have been a licensed, registered nurse in Alabama since 1985. I hold a Bachelor's Degree in nursing from Troy State University. Since 1985, I have practiced nursing in a variety of positions and settings. In particular, I have worked as a nurse at Easterling Correctional Facility in Clio, Alabama, since March of 2001. Since November 3, 2003, I have been employed as the Health Service Administrator (H.S.A.) for Easterling Correctional Facility by Prison Health Services, Inc., the company which currently contracts with the Alabama Department of Corrections to provide medical services to inmates.

Lonnie Cammon (AIS #236498) is an inmate who was incarcerated at Easterling Correctional Facility from August 22, 2005 through May 31, 2006 when he was transferred to Bullock County Correctional Facility. I am familiar with Mr. Cammon and have been involved with the medical and nursing services provided to him at Easterling. In addition, I have reviewed Mr. Cammon's Complaint in this action as well as his medical records (certified copies of which are being produced to the Court along with this Affidavit).

It is my understanding that Mr. Cammon has filed a Complaint in this matter alleging that the nursing staff at Easterling failed to provide him with appropriate medications during the year 2006 and, as a result of this failure, Mr. Cammon was caused to suffer a stroke. Mr. Cammon's allegations are simply unfounded.

Mr. Cammon was maintained with numerous medications while incarcerated at Easterling during the year 2006. Specifically, Mr. Cammon was prescribed Ditropan[1], NitroQuick/Nitroglycerin[2], Aspirin[3], Mevacor[4], Tylenol, KCL, Bactrim[5], Isordil[6], Lasix[7], Zantac[8], Prednisone[9], Feldene[10] Cosopt[11], Colchicine[12], Artificial tears, Miconazole

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[1] Ditropan is indicated to help control the symptoms of overactive bladder.
[2] Nitroglycerin dilates blood vessels to prevent angina.
[3] Prevention and treatment of stroke and heart attack.
[4] Mevacor is indicated for treatment of high cholesterol.
[5] Bactrim is an antibiotic.
[6] Isordil is prescribed to relieve or prevent angina pectoris. Isordil dilates the blood vessels by relaxing the muscles in their walls.
[7] Lasix is a loop diuretic (water pill) that prevents the body from absorbing too much salt, allowing the salt to instead be passed in urine.
[8] Zantac is in a class of drugs called histamine receptor antagonists. Zantac works by decreasing the amount of acid the stomach produces.
[9] Prednisone is used alone or with other medications to treat the symptoms of low corticosteroid levels (lack of certain substances that are usually produced by the body and are needed for normal body functioning).
[10] Feldene, a nonsteroidal anti-inflammatory drug, is used to relieve the inflammation, swelling, stiffness, and joint pain associated with rheumatoid arthritis and osteoarthritis.
[11] Cosopt lowers high pressure in the eye, a problem typically caused by the condition known as open-angle glaucoma. Cosopt works by reducing production of the liquid that fills the eyeball.
[12] Colchicine is used to prevent or treat attacks of gout.

Cream[13] and Bengay. These medications were prescribed to Mr. Cammon by Easterling's Medical Director, Jean Darbouze, M.D., and were adjusted by Dr. Darbouze as warranted by his changing medical condition. The nursing staff at Easterling gave Mr. Cammon his medications as prescribed. There is no indication that any of Mr. Cammon's medications have caused him to suffer a stroke.

Based on my review of Mr. Cammon's medical records, and on my personal knowledge of the treatment provided to him, it is my opinion that his medical conditions were evaluated and treated in a timely and appropriate fashion at Easterling Correctional Facility. At all times, myself and the other healthcare providers at Easterling exercised the same degree of care, skill, and diligence as other similarly situated health care providers would have exercised under the same or similar circumstances. In other words, it is my opinion that the appropriate standard of care was adhered to at all times in providing medical care, nursing care, evaluation, and treatment to this inmate. At no time did I or any of the medical or nursing staff at Easterling deny Mr. Cammon any needed medical or nursing treatment, nor did we ever act with deliberate indifference to any serious medical need of Mr. Cammon. At all times, Mr. Cammon's medical conditions were addressed as promptly as possible under the circumstances."

Further affiant sayeth not.

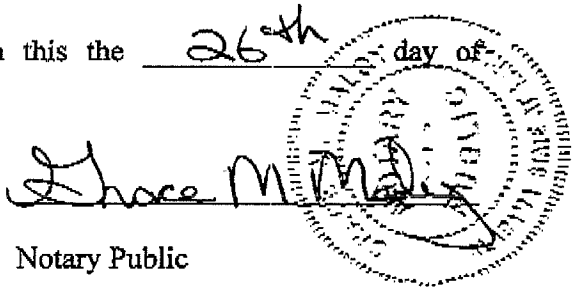
Kay Wilson, RN/ HSA

KAY WILSON, R.N., H.S.A.

[13] Miconazole cream is an antifungal type of antibiotic. Miconazole cream is used to treat fungal skin infections such as candida, ringworm, athlete's foot, and jock itch.

STATE OF ALABAMA)
)
COUNTY OF Barbour)

Sworn to and subscribed before me on this the 26th day of October, 2006.



Notary Public

My Commission Expires:

03/31/07.